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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12501

Reg. No.

|  |  |   |  |  |   |  |  |   |
|--|--|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>BESSIE MCMILLAN</b>                               |   |  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>23</b> Year <b>1997</b> |  | 3. Time of Death<br><b>14:15</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |  | 4c. County of Death<br><b>N/A</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-09-7738</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 17, 1912</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b> |
|  | Usual Residence of Decedent  |   |  |  |   |  |  |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>1600 Mt. Royal Ave. Apt. 1304</b>   |  |   |  | 10f. Zip Code<br><b>21217</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+)   |  |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>   |   | 18b. Kind of Business/Industry<br><b>Outside Home</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>William Thomas</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Matilda Jane Granton</b>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ms. Marsha Blake Granddaughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1141 Versailles Circle Apt F Balto. Md. 21204</b>  |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>Balto. Co. Md.</b>   |   | 20d. Date<br><b>4/28/97</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>   |  |   |  | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md. 21216</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death                      |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|  |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicida <input type="checkbox"/> Homicida  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                                 |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br><b>Adriana Andrade, MD</b>  |  |   |  | 29c. License number<br><b>P 10579</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 23, 1997</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Good Samaritan Hospital 5601 Loch Raven Boulevard, Baltimore, MD 21239-2995</b>   |  |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 25 1997</b>  |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12502

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Mary Anna Mach   |  | 2. Date of Death<br>Month Day Year<br>April 24, 1997  |  | 3. Time of Death<br>5:10AM   |
|  | 4a. Facility Name (If not institution, give street and number)<br>Franklin Woods Nursing Home  |  | 4b. City, Town, or Location of Death<br>Rosedale  |  | 4c. County of Death<br>Baltimore   |
| Funeral<br>Director  | 5. Social Security Number<br>217-40-3436   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>80 Yrs.   | If Under 1 Year<br>Months Days                 | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br>11-13-16  |  | 9. Birthplace (State or Foreign Country)<br>MD  |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |  |   |  |  |
|  | 10a. State<br>MD   | 10b. County<br>Baltimore   | 10c. City, Town or Location<br>Rosedale   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br>1315 Spring Ave.   |  | 10f. Zip Code<br>21237  |  | 10g. Citizen of What Country?<br>USA   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0                               |  |  |
|  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Own Home  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Joseph Vonasek  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Frances (unk.)   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Robert Mach St./Son  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>838 East Wheel Rd., Bel Air, MD 21015                |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holy Redeemer Cemetery  |  | 20c. Location - City or Town, State<br>Baltimore, MD   |
|  | 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility<br>Cvach/Rosedale Funeral Home<br>1211 Chesaco Ave. Baltimore, MD 21237  |  |  |
| Physician<br>/Medical<br>Examiner  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br>b. Ischemic coronary artery disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes, Mellitus,<br>Atrial Fibrillation   |  |   |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  |  |
|  | 28a. Date of injury (Month, Day Year)<br>28b. Time of injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |
| 29b. Signature and title of certifier<br>Susan Ley, MD   |  | 29c. License number<br>D33943  |   | 29d. Date signed (Month, Day, Year)<br>4/25/97 |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Franklin Square Hospital BALTIMORE, MD 21237 |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 25 1997   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 887997

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12503

Item:28b per MEO G-746 4/25/97 reb

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |  |  |
|--|--|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Evelyn W. Mann   |   |   |  | 2. Date of Death<br>Month Day Year<br>April 22 1997  |   | 3. Time of Death<br>4:59 p.m.  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Johns Hopkins Bayview Medical Center |   |   |  | 4b. City, Town, or Location of Death<br>Baltimore  |   | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director  | 5. Social Security Number<br>008-12-5136   |   | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>92 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>April 20, 1905  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Vermont  |   |   |  |  |   |  |  |
| Usual Residence of Decedent  |  |   |   |  |  |   |  |  |
| 10a. State<br>Md.  |  | 10b. County<br>Baltimore  |   | 10c. City, Town or Location<br>Edgemere  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>2829 Lodge Farm Rd.  |  |   |   | 10f. Zip Code<br>21219   |  | 10g. Citizen of What Country?<br>USA  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) 2 yrs.  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales                                     |  |   | 16b. Kind of Business/Industry<br>Retail   |  |
| 17. Father's Name (First, Middle, Last)<br>John Earl Mann Sr.  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lora Weatherhead Mann   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Marilyn Sowards  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8036 Kimberly Rd. Dundalk Md. 21222                   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Morningside Cem.  |  | Date<br>4-27   |   | 20c. Location - City or Town, State<br>Vermont   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br>Connolly Funeral Home of Dundalk<br>7110 Sollers Point Rd. 21222   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Left hip fracture with complications<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Moderately severe aortic stenosis with hypertrophied septum  |  |   |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br>4/19/97   |   | 28b. Time of Injury<br>5:30 P. M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br>Fell and broke hip  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br>D/2844  |  | 29d. Date signed (Month, Day, Year)<br>4/24/97  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Michael H. Huo, MD 4940 Eastern Avenue, Baltimore, MD 21224  |  |   |   | Johns Hopkins Bayview Medical Center   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 25 1997   |  | 32. Registrar's Signature<br>   |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 12504

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |   |   |  |
|--|---|---|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Dorothy L. Moran</b>   |   |  |   | 2. Date of Death<br>Month Day Year<br><b>April 23, 1997</b>  |   | 3. Time of Death<br><b>1:15 A.M.</b>                                    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>7 Calvary Court</b>  |   |  |   | 4b. City, Town, or Location of Death<br><b>Lutherville</b>   |   | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-16-7305</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>72</b>               | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>4-21-1925</b>                 | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent   |   |  |   |  |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Lutherville</b>  |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>1412 Bellona Ave.</b>  |   |  |   | 10f. Zip Code<br><b>21093</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>              |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John Stansbury</b>  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anne Watts</b>   |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs Katie Moran (Daughter)</b>   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7 Calvary Court, Lutherville, Maryland 21093</b>   |   |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gards.</b>                                |   | 20c. Location - City or Town, State<br><b>4-25-97 Timonium, Maryland</b>   |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Wallace S. Brooks Jr.</b>   |   |  |   | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road, Towson, Md. 21204</b>  |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Retroperitoneal Sarcoma</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |  |   |  |   |   | Approximate Interval Between Onset and Death<br><b>4 years</b>   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive pulmonary disease</b>  |   |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>                           |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 28d. Describe how Injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>Christine J. Lafferman, M.D.</b>  |  | 29c. License number<br><b>D33211</b>                      |  | 29d. Date signed (Month, Day, Year)<br><b>4/24/97</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Christine J. Lafferman, M.D. 1407 York Road, Lutherville, Maryland 21093</b>  |   |   |  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 25 1997</b>  |   |   |  | 32. Registrar's Signature<br><b>Carla Swanson-Randall</b> |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

97 12505

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |  |
|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Eugene F. MARTIN</b>   |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>21</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>1:37 pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-22-9264</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 9, 1928</b>                                  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Baltimore County</b>                                      |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>7716 Bagley Avenue</b>   |  | 10f. Zip Code<br><b>21234</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>Korean</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10 yrs.</b><br>College (1-4 or 5+) <b>N/A</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Policeman</b>                                     |  | 16b. Kind of Business/Industry<br><b>Baltimore County</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles Martin</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Bradley</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. E. Christine Martin</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7716 Bagley Avenue Baltimore, Maryland 21234</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  | 20d. Date<br><b>4-25-97</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Lassahn Funeral Home</b><br><b>7401 Belair Rd. Baltimore, Maryland 21236</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Multiple Myeloma</b><br>Due to (or as a consequence of):<br><br>b. <b>End Stage Renal Disease</b><br>Due to (or as a consequence of):<br><br>c. <b>Pancytopenia Secondary to Chemotherapy</b><br>Due to (or as a consequence of):<br><br>d. <b>Sepsis</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |
|  | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>RD1917</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 21, 1997</b>                                |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Savitha Shivananda M.D. 9000 Franklin Square Drive, Baltimore, MD 21237</b>  |  |   |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>APR 25 1997</b>   |  |   |  | 32. Registrar's Signature<br>  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

97 12506

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances Nicholes

2. Date of Death

Month Day Year  
APRIL 22 19973. Time of Death  
2145

4a. Facility Name (If not institution, give street and number)

Deaton Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-01-3429

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs., last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 17, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State  
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

X Yes 2 ☐ No

10e. Street and Number

2221 Walbrook Ave.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Doctor's Office

17. Father's Name (First, Middle, Last)

Robert Edwards

18. Mother's Name (First, Middle, Maiden Surname)

Clara Brown

19a. Informant's Name/Relationship (Type, Print)

Mrs. Marie Cornish (cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2121 N. Smallwood St. Balto. Md. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

4/28/97

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute congestive failure  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

wks

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Generalized anasarca  
Due to (or as a consequence of):

wks.

c. Old pulmonary tuberculosis  
Due to (or as a consequence of):

yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28f. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph L. Russ MD

29c. License number

D34974

29d. Date signed (Month, Day, Year)

April 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charu Mohita, 5865 Robert Oliver place, #121, Columbia, MD 21046

31. Date filed (Month, Day, Year)

APR 25 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate filed in by the funeral director.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12507

|   |   |                          |   |  |  |  |  |  |
|---|---|--------------------------|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Kathleen Ack Nichol                           |                          |   |  | 2. Date of Death<br>Month Day Year<br>April 21 1997  |  | 3. Time of Death<br>9:30pm   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Ivy Hall Nursing Center |                          |   |  | 4b. City, Town, or Location of Death<br>Middle River   |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director   | 5. Social Security Number<br>216-09-7667  |                          | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>88 Yrs.  |  | 6. Under 1 Year<br>Months Days   |  |
|   |   |                          |   |  |  |  | 8. Date of Birth (Month, Day, Year)<br>March 22, 1909  |  |
|   |   |                          |   |  |  |  |  | 9. Birthplace (State or Foreign Country)<br>Maryland |
| Usual Residence of Decedent   |   |                          |   |  |  |  |  |  |
| 10a. State<br>Md.   |   | 10b. County<br>Baltimore |   | 10c. City, Town or Location<br>Middle River  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>1203 Shore Road   |   |                          |   | 10f. Zip Code<br>21220   |  | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th College (1-4 or 5+)   |   |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife               |  |  | 16b. Kind of Business/Industry<br>own home   |  |
| 17. Father's Name (First, Middle, Last)<br>Edward Ack   |   |                          |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rhoda Huff  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Vicki Topolnicke/daughter   |   |                          |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1203 Shore Road Baltimore MD. 21220 |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holly Hill Cemetery   |  | Date<br>4/24/97  |  | 20c. Location - City or Town, State<br>Baltimore Md.   |  |
| 21. Signature of Funeral Service Licensee<br>R. Terry Connolly  |   |                          |   | 22. Name and Address of Facility<br>Connolly Funeral Home of Essex<br>300 Mace Ave. Baltimore Md. 21221                              |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>arteriosclerotic coronary heart disease</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                          |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |                          |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                          |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |                          |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                          |   |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |                          |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |                          | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|   |   |                          | 28d. Describe how injury occurred   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |  |
|   |   |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                          |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>Louis Semenov  |   |                          |   | 29c. License number<br>D10032  |  | 29d. Date signed (Month, Day, Year)<br>April 22, 1997                                  |  |  |
| 30. Name and address of person who completed cause of death (Name 23a) (Type, Print)<br>LOUIS SEMENOV 2108 CRENSHAW BAL MD 21220  |   |                          |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 25 1997  |   |                          |   | 32. Registrar's Signature<br>John Davidson-Randall   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12508

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Natalie Paulhamus

2. Date of Death

Month Day Year  
April 22 1997

3. Time of Death

5:53PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

219-68-8832

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

8

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
January 3, 1989

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3808 Greenmount Avenue

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
1

College (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

William

Artley

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Williams Paulhamus

19a. Informant's Name/Relationship (Type, Print)

Thaddeus Paulhamus Uncle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3808 Greenmount Avenue Baltimore, Maryland 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Oak Grove Cemetery

Date

4/28/97

20c. Location - City or Town, State

Tyrone Pennsylvania

21. Signature of Funeral Service Licensee

Dennis M. Knaus

22. Name and Address of Facility

Mitchell-Wiedefeld Home  
6500 York Road Baltimore, Maryland 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumocystis carinii pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 month

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Acquired Immunodeficiency Syndrome

Due to (or as a consequence of):

3 years

c. Human Immunodeficiency Virus

Due to (or as a consequence of):

8 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

R. Skyles McCurley M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

April 23 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Skyles McCurley 6448 Ducketts Lane Elkridge MD 21227

31. Date filed (Month, Day, Year)

APR 25 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12509

ITEM:3 G-747 5-6-97 PER DR. eoh

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Evelyn Frederick Provenzano

2. Date of Death

Month Day Year  
April 22, 1997

3. Time of Death

P.M.  
6:50 A.M.

4a. Facility Name (If not institution, give street and number)

5704 Carroll Dale Avenue

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

5. Social Security Number

217-07-8737

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 30, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3838 Roland Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

C &amp; P Telephone Co.

17. Father's Name (First, Middle, Last)

Lloyd Baltozer Loats

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Norine Frederick

19a. Informant's Name/Relationship (Type, Print)

M. Elizabeth Chouinard

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5704 Carroll Dale Drive Sykesville, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

4/26/97

20c. Location - City or Town, State

Pikesville, MD

21. Signature of Funeral Service Licensee

Stephen M. Jenkins

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Severe hypoxemia

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

Progressive respiratory failure

3 weeks

c.

Due to (or as a consequence of):

Severe emphysema

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stanley M. Rosen MD

29c. License number

DD9775

29d. Date signed (Month, Day, Year)

4/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stanley M. Rosen MD 2435 W. Belvedere Ave. 21215

31. Date filed (Month, Day, Year)

APR 25 1997

Registrar's Signature

Julie Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12510

## Certificate of Death

Reg. No.

|  |  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Wilma H. Potter</b>   |  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>23</b> , Year <b>1997</b>  |  |   |  | 3. Time of Death<br><b>2:45 p.m.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>76 Pendragon Court</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Reisterstown</b>  |  |   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-26-0222</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.  |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 14, 1928</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Reisterstown</b>  |  |
| To Be Completed by Funeral Director                                  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>76 Pendragon Court</b>  |  | 10f. Zip Code<br><b>21136</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |
|  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10 Years</b><br>College (1-4 or 5+) |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  |
| To Be Completed by Physician/Medical Examiner                        | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>William LeCompte</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Violet Bisser</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. John Potter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>45 Caraway Road Reisterstown, Maryland 21136</b>  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt Olive U.M. Ch. Cem.</b>  |  | 20c. Location - City or Town, State<br><b>4/26/97 Randallstown, MD</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Stephen M Jenkins</b>   |  | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, MD 21133</b>  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Arteriosclerotic Cardio Renal/Vascular Disease</b>   |  | Due to (or as a consequence of):   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   |  | Due to (or as a consequence of):   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                     |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Dr. Charles F. O'Donnell</b>   |  | 29c. License number<br><b>09383</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 25, 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Charles F. O'Donnell 111 Hamlet Hill Road Balto. MD</b>  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>APR 25 1997</b>  |  | 32. Registrar's Signature<br><b>Jill Davidson-Randall</b>  |  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



97-1969-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12511

## Certificate of Death

Reg. No.

|   |   |  |  |   |  |  |  |   |
|---|---|--|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>THERESA PALAIA</b>   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 20 1997</b>   |  | 3. Time of Death<br><b>7:56 P.M.</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>CITY</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>159-18-6004</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.          | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                               | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 29, 1919</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b> |
|   | Usual Residence of Decedent   |  |  |   |  |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>CITY</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>28 NORTH KENWOOD AVENUE</b>  |  |  |   | 10f. Zip Code<br><b>21224</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SEAMSTRESS</b>   |   | 16b. Kind of Business/Industry<br><b>CLOTHING</b>  |  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>FRANK PALAIA</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>  |  |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>EDNA PALAIA/SISTER-IN-LAW</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2500 GRAY MANOR TERRACE BALTIMORE, MARYLAND 21222</b>                                    |  |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH CEMETERY</b>   |   | 20c. Date<br><b>4/24</b>   |  | 20d. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>                              |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Elizabeth Selinski</i>  |  |  |   | 22. Name and Address of Facility<br><b>CHARLES S. ZEILER, INC.<br/>6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224</b>   |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |  |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>  |  |  |   |  |  |  |   |
| To Be Completed by Physician/Medical Examiner   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   | 24a. Was an autopsy performed?<br><b>DISSECTION</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|   | 28d. Describe how injury occurred   |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |   |  |  |  |   |
| 29b. Signature and title of certifier<br><i>Wayne Doney</i>   |   |  |  | 29c. License number<br><b>O.C.M.E.</b>                    |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 21, 1997</b> |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MD By Dmrt P. Koron 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 25 1997</b>   |   |  |  | 32. Registrar's Signature<br><i>Lisa Davidson-Randall</i> |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12512

|  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Anna Margaret Phillips  |  |   |  | 2. Date of Death<br>Month Day Year<br>April 24, 1997   |  | 3. Time of Death<br>1035   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center   |  |   |  | 4b. City, Town, or Location of Death<br>Annapolis  |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-16-1348  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>77 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Jun. 23, 1919                                 |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>MD  |  | 10b. County<br>Anne Arundel  |  | 10c. City, Town or Location<br>Annapolis   |  |
| To Be Completed by Funeral Director                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>119 Gardner Drive   |  | 10f. Zip Code<br>21403   |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Executive Secretary                      |  | 16b. Kind of Business/Industry<br>N.S.A.   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Lee Ehrlinger  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Bamberger  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>John B. Phillips - Husband  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>119 Gardner Drive, Annapolis, MD 21403  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hillcrest Cemetery  |  | Date<br>4/28   |  | 20c. Location - City or Town, State<br>Annapolis, MD                                 |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Patrick J. Hendel</i>   |  | 22. Name and Address of Facility<br>Hardesty Funeral Home, P.A.<br>12 Ridgely Ave. Annapolis, MD 21401  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. COPD - Emphysema<br>Due to (or as a consequence of):<br>b. Cigarette abuse<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br><i>Joseph F. Friend</i>  |  |   |  | 29c. License number<br>MD 965  |  | 29d. Date signed (Month, Day, Year)<br>4/24/97                                       |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>205 Ridgely Ave Annapolis, Md. 21401  |  |   |  | 31. Date filed (Month, Day, Year)<br>APR 25 1997   |  |  |  |
|  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene **97 12513**  
Certificate of Death

Reg. No.

|  |   |   |  |  |   |  |  |  |
|--|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William George Quigley</b>   |   |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>23</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>7:00am</b>  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>1731 Bayard Ave.</b>   |   |  |  | 4b. City, Town, or Location of Death<br><b>Dundalk</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>206-28-5209</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 17, 1917</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |   | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Dundalk</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  | 10e. Street and Number<br><b>1731 Bayard Ave.</b>   |  | 10f. Zip Code<br><b>21222</b>  |  |
|  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942-1945</b> |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b><br>College (1-4 or 5+) <b>5+ yrs.</b>   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>   |  |  |  |
|  | 16b. Kind of Business/Industry<br><b>Balto. County</b>  |   |  |  | 17. Father's Name (First, Middle, Last)<br><b>William George Quigley</b>  |  |  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Harritt Donahue</b>   |   |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marge Quigley wife</b>   |  |  |  |
|  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1731 Bayard Ave. Dundalk Md. 21222</b>  |   |  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest V.A. 4-28</b>  |   |  |  | 20c. Location - City or Town, State<br><b>Garrison</b>  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |  |  | 22. Name and Address of Facility<br><b>Connolly Funeral Home Of Dundalk<br/>7110 Sollers Point Rd 21222</b>   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Lung cancer with metastasis</b><br>Due to (or as a consequence of):<br>b. <b>LV dysfunction</b><br>Due to (or as a consequence of):<br>c. <b>COPD</b><br>Due to (or as a consequence of):<br>d. |   |  |  | Approximate Interval Between Onset and Death  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 28d. Describe how injury occurred  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                     |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |   |   |  | 29c. License number<br><b>D44793</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4-23-97</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR. SINAI 6730 HOLMBIRD AVE. DUNDALK MD. 21222</b>  |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 25 1997</b>  |   |   |  | 32. Registrar's Signature<br> |   |  |  |  |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12514

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NANCY ANN ROSENSTOCK-WHITTAKER

2. Date of Death

Month Day Year  
APRIL 22, 1997

3. Time of Death

3:20 pm

4a. Facility Name (If not institution, give street and number)

6017 Twilight Court

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217541014

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 11, 1950

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6017 Twilight Court

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assistant Principle

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Albert Milke Jr

18. Mother's Name (First, Middle, Maiden Surname)

Alma Edwards

19a. Informant's Name/Relationship (Type, Print)

James E. Whittaker / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6017 Twilight Court Baltimore, Md 21206

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

4/24/97

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Cvach/Rosedale Funeral Home  
1211 CHESACO AVE 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Cancer  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

518320

29d. Date signed (Month, Day, Year)

4/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Fettinghoff, Johns Hopkins Oncology Center Bldg. MD 21287

31. Date filed (Month, Day, Year)

APR 25 1997

32. Registrar's Signature

Julian Windsor-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12515

## Certificate of Death

Reg. No.

|   |   |  |  |                                |  |
|---|---|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Edith Reynolds</b>   |  | 2. Date of Death<br>Month Day Year<br><b>April 22 1997</b>   |                                | 3. Time of Death<br><b>0420<sup>A</sup></b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Agnes Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-14-1155</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | Usual Residence of Decedent   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 2, 1916</b>   |                                | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Howard</b>   | 10c. City, Town or Location<br><b>Ellicott City</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>11710 Rt. 144</b>  |  | 10f. Zip Code<br><b>21042</b>  |                                | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>Collage (1-4or 5+)   |                                | 16. Kind of Business/Industry<br><b>Retail</b>   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Samuel Reynolds</b>   |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Ada Madison Turner</b>  |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sharon Ziegler / Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11710 Rt. 144, Ellicott City, MD 21042</b>   |                                |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>  |                                | 20c. Location - City or Town, State<br><b>4/24/97 Baltimore, MD</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>Thomas Gregor</b>   |  | 22. Name and Address of Facility<br><b>Loudon Park Funeral Home<br/>3620 Wilkens Ave., Baltimore, MD 21229</b>   |                                |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Aspiration PNEUMONIA</b><br><b>COPD</b>   |  |  |                                | Approximate Interval Between Onset and Death<br><b>1 week</b>  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |                                |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |                                |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |                                |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |                                | 28b. Time of Injury<br><b>M</b>  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |                                |  |
| State Registrar                               | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Diglisic GORDANA</b>   |                                | 29c. License number<br><b>PO 9886</b>  |
|   | 29d. Date signed (Month, Day, Year)<br><b>April 22 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DIGLISIC GORDANA, ST. AGNES HOSPITAL</b>  |                                |  |
|   | 31. Date filed (Month, Day, Year)<br><b>April 22 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |                                |  |
|   | 33. Registrar's Signature   |  |  |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 12516

Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |   |   |  |  |
|---|---|---|--|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MILDRED REYNOLDS</b>                                     |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 20 1997</b> |  | 3. Time of Death<br><b>8:57 am</b>                          |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HOWARD COUNTY GENERAL HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>COLUMBIA</b>    |  | 4c. County of Death<br><b>HOWARD</b>                        |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-20-5348</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>SEP. 19, 1924</b> |   |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Baltimore</b>                            |  | 10c. City, Town or Location<br><b>Baltimore Highlands</b>   |   |  |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>2824 Hoffman Avenue</b>   |  | 10f. Zip Code<br><b>21227</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                                     |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>              |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business/Industry<br><b>Exporting-Shapiro</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>William Groetzinger</b>                |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Krumholtz</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Steven William Reynolds - son</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2824 Hoffman Avenue, Baltimore, Md. 21227</b>  |  |  |   |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>  |  | 20c. Location - City or Town, State<br><b>Elkridge, Md.</b>  |  | 20d. Date<br><b>4/22/97</b>  |   |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home at Meadowridge<br/>7250 Washington Blvd., Elkridge, Md. 21227</b>  |  |  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>METASTATIC CARCINOMATOSIS</b><br>Dua to (or as a consequence of):<br>b. <b>from breast cancer</b><br>Dua to (or as a consequence of):<br>c.<br>Dua to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |   |   | Approximate Interval Between Onset and Death<br><b>1 month</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D13044 (MD)</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 25, 1997</b>                         |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Frank Gross, M.D. 2 Knoll North Drive/Columbia, MD 21045</b>   |   |   |  |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 25 1997</b>   |   | 32. Registrar's Signature<br>  |  |  |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 12517

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND ROBINSON

2. Date of Death

Month Day Year  
APRIL 12 1997

3. Time of Death

1:30 P

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

CITY

Funeral  
Director

5. Social Security Number

220-74-2007

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 8, 1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

None

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4016 Old Frederick Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Afro American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Honor Robinson

19a. Informant's Name/Relationship (Type, Print)

Barbara Robinson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5522 Liberty Height Ave. Balt. Md 21207

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

4/19/97

20c. Location - City or Town, State

Lansdowne, Maryland

21. Signature of Funeral Service Licensee

HARRY M. CULLAN

22. Name and Address of Facility

Wallace Funeral Service  
3405 W. Franklin Street  
BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

GASTROINTESTINAL BLEEDING

Due to (or as a consequence of):

b.

LIVER FAILURE - PORTAL HYPERTENSION

Due to (or as a consequence of):

c.

AIDS

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE - THROMBOCYTOPENIA -

GRAM NEGATIVE SEPSIS - CACHEXIA -

ELECTROLYTE IMBALANCE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Schylabone MD

29c. License number

D19057

29d. Date signed (Month, Day, Year)

APRIL 12, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PELAYO E. CORREA MD

LIBERTY MEDICAL CENTER

31. Date filed (Month, Day, Year)

APR 25 1997

32. Registrar's Signature

Gina Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 12518

Reg. No.

|   |  |   |  |                                      |   |  |   |  |
|---|--|---|--|--------------------------------------|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Dimitrie Suciu</b>  |   |  |                                      | 2. Date of Death<br>Month <b>April</b> Day <b>19</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>2:25 PM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Bon Secours Hospital</b>  |   |  |                                      | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-10-6086</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |                                      | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>April 13, 1916</b>            |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10e. State<br><b>Maryland</b>  |                                      | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>                         |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |   |  |                                      | 10f. Zip Code<br><b>21223</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1943-</b><br>If Yes, Give Year or Dates: <b>1945</b> |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Metal Worker</b>   |                                      | 16b. Kind of Business/Industry<br><b>Manufacturing</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Vasile Suciu</b>   |   |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sida Florut</b>   |  |   |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Maria F. Suciu / Wife</b>   |   |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1236 Glyndon Ave., Baltimore, MD 21223</b>  |  |   |  |
|   | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>  |                                      | Date<br><b>4/23/97</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>       |  |
|   | 21. Signature of Funeral Service licensee<br><i>[Signature]</i>  |   |  |                                      | 22. Name and Address of Facility<br><b>Loudon Park Funeral Home<br/>3620 Wilkens Ave., Baltimore, MD 21229</b>  |  |   |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Massive Pulmonary Embolism</b><br>Due to (or as a consequence of):<br><b>Exploratory Lap. Repair</b><br>Due to (or as a consequence of):<br><b>Ventral Incisional Hernia</b><br>Due to (or as a consequence of): |   |  |                                      |   |  |   |  |
|   | 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Massive Pulmonary Embolism</b><br>Due to (or as a consequence of):<br><b>Exploratory Lap. Repair</b><br>Due to (or as a consequence of):<br><b>Ventral Incisional Hernia</b><br>Due to (or as a consequence of): |   |  |                                      |   |  |   |  |
|   | 23c. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Massive Pulmonary Embolism</b><br>Due to (or as a consequence of):<br><b>Exploratory Lap. Repair</b><br>Due to (or as a consequence of):<br><b>Ventral Incisional Hernia</b><br>Due to (or as a consequence of): |   |  |                                      |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |                                      |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|   |  |   |  |                                      |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
|   |  |   |  |                                      |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                      |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>      |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   |  | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred    |   |  |   |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D25909</b> |   | 29d. Date signed (Month, Day, Year)<br><b>4/22/97</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ETEM E. Imoke 4713 Leeds Ave, Baltimore, MD 21227</b>  |  |   |  |                                      |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 25 1997</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |                                      |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

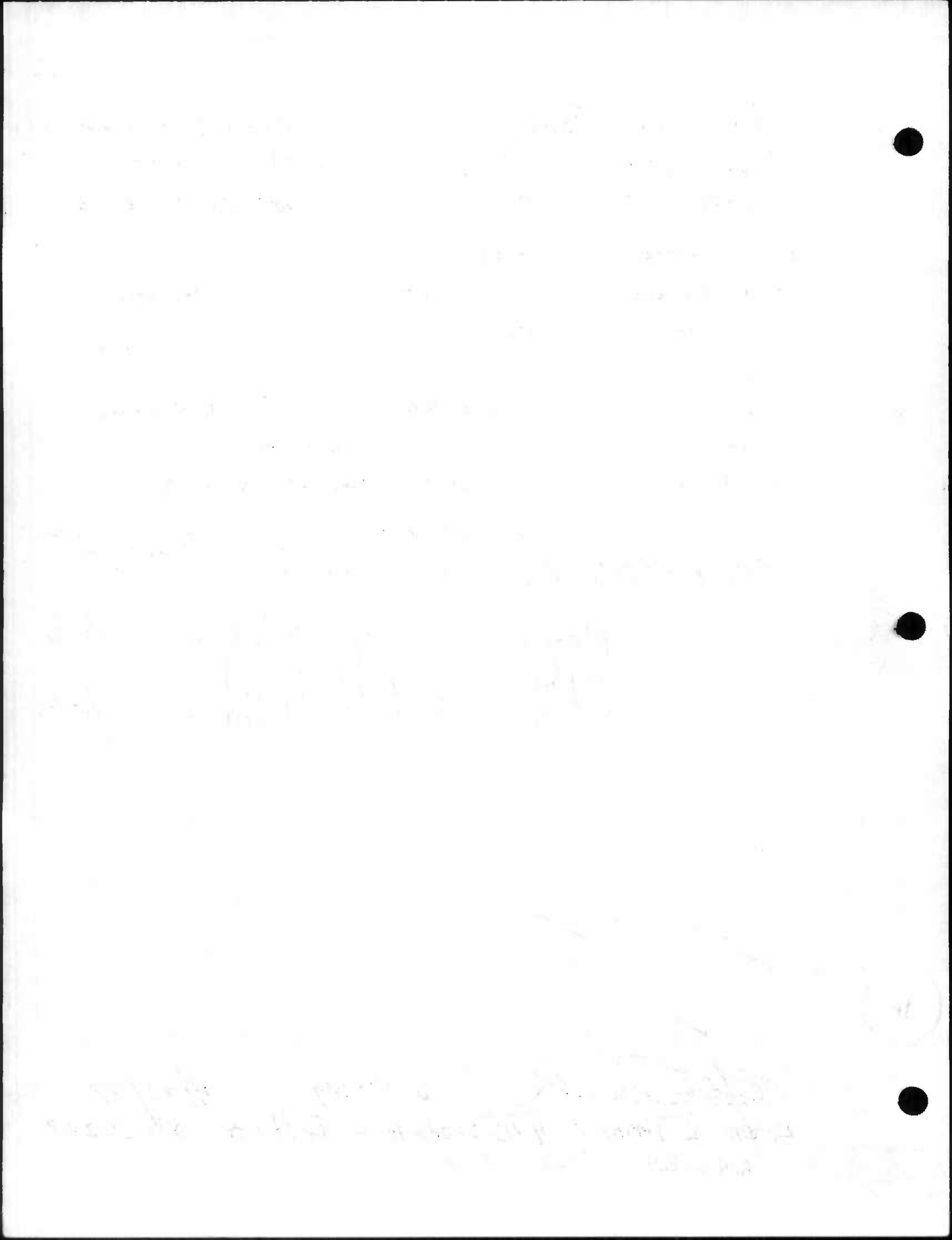
Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12519

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irma Hausman Schmitt

2. Date of Death

Month Day Year  
April 24, 1997

3. Time of Death

8:25a.m.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Brook Grove Nursing Home

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

085-36-6610

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 19, 1905

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Laytonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6401 Manor View Drive

10f. Zip Code

20882

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Karl Hausman

18. Mother's Name (First, Middle, Maiden Surname)

Wilhelmina (Unavailable)

19a. Informant's Name/Relationship (Type, Print)

Rev. Charles P. Schmitt/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6401 Manor View Drive, Laytonsville, Maryland 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Union Cemetery

Date

4/29

20c. Location - City or Town, State

Burtonsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Arteriosclerotic Cardiovascular Disease

Years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D08381

29d. Date signed (Month, Day, Year)

April 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Benjamin Avrunin 18111 Prince Philip Drive, Olney, Maryland 20832

31. Date filed (Month, Day, Year)

APR 25 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 12520

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Sterner

2. Date of Death  
Month Day Year

April 21, 1997

3. Time of Death

7:03 AM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

578-07-0005

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

July 14, 1914

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

536 Tufts Drive

10f. Zip Code

21227

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

Collegiate (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Meat Packing

17. Father's Name (First, Middle, Last)

Frank Sterner

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Seipel

19a. Informant's Name/Relationship (Type, Print)

Margaret Mazur/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17804 Striley Drive, Ashton, Maryland 20861

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

4/24

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

James A. Baker

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiac Dysrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

acute

b. CAD

Due to (or as a consequence of):

years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James A. Baker MD

29c. License number

D42187

29d. Date signed (Month, Day, Year)

April 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES DAY 11055 Little Patuxent Parkway Columbia MD 21044

31. Date filed (Month, Day, Year)

APR 25 1997

32. Registrar's Signature

John Davidson-Hendall

State  
Registrar

Baltimore, Maryland 21215-0020

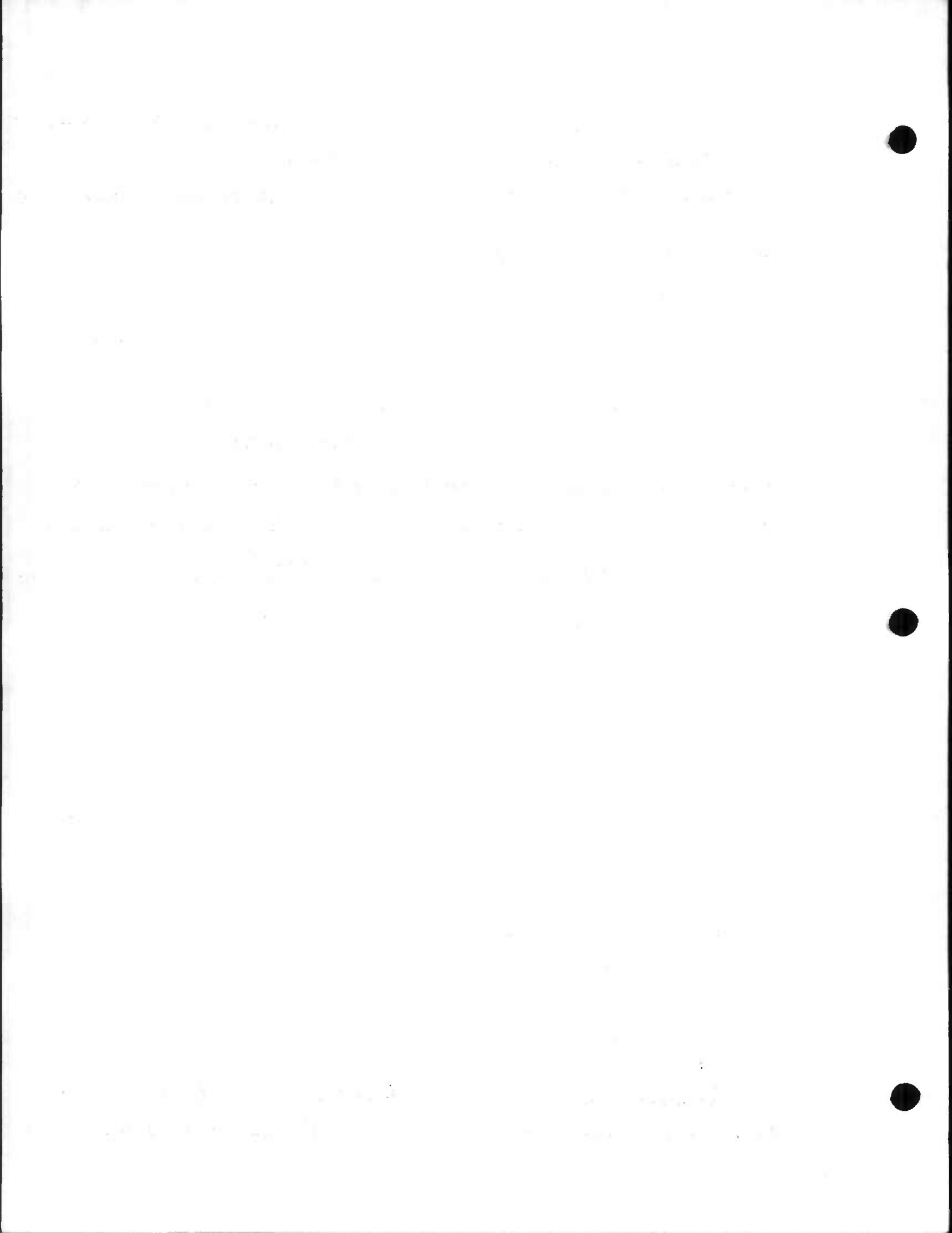
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed with the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item: 27 per MEO G-748 6/11/97 dh

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a-f per MEO G-748 5/16/97 reb

Certificate of Death

Reg. No.

97 12521

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |   |  |  |  |
|--|--|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JAMIE LYNN SIMMONS</b>  |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 17, 1997</b>   |  | 3. Time of Death<br><b>10:40 AM</b>          |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>12802 BALTIMORE AVE.</b>  |  |   | 4b. City, Town, or Location of Death<br><b>BELTSVILLE</b>   |  | 4c. County of Death<br><b>PRINCE GEORGE</b>  |  |
| 5. Social Security Number<br><b>UNAVAILABLE</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>1</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.               | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 1, 1996</b>   |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |   |  |  |  |
| Usual Residence of Decedent  |  |   |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>PRINCE GEORGE</b>   |   | 10c. City, Town or Location<br><b>BELTSVILLE</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>12802 BALTIMORE AVENUE</b>  |  |   | 10f. Zip Code<br><b>20707</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>                                 |  | 16b. Kind of Business/Industry<br><b>N/A</b> |  |
| 17. Father's Name (First, Middle, Last)<br><b>JAMES ALLAN SIMMONS</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CHRISTINE ENGLISH</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JAMES A. SIMMONS/FATHER</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7608 SOUTH ARBORY COURT, LAUREL, MARYLAND 20707</b> |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>IVY HILL CEMETERY</b>  |   | 20c. Location - City or Town, State<br><b>LAUREL, MARYLAND</b>   |  | 20d. Date<br><b>4/23</b>   |
| 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>FLECK FUNERAL HOME, INC.<br/>7601 SANDY SPRING ROAD, LAUREL, MD 20707</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Smoke Inhalation</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>found on 4/17/97</b>   |   | 28b. Time of Injury<br><b>found at 9:00</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Found at home</b>  |   | 28d. Describe how injury occurred<br><b>Unknown</b>  |  |  |
|  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>12802 Baltimore Ave. Baltimore, Maryland</b>  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and Title of certifier<br>   |   | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 18, 1997</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 25 1997</b>  |  | 32. Registrar's Signature<br>   |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12522

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |   |  |   |
|---|--|--|---|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Frank Winford Thwaite</b>   |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>23</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>2:55 PM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Greater Baltimore Medical Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |   | 4c. County of Death<br><b>Baltimore</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-07-7352</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 25, 1914</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent  |  |   |  |  |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Towson</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>205 E. Joppa Rd.</b>  |  |   |  | 10f. Zip Code<br><b>21286</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Selfemployed</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Selfemployed</b>                  |  |  |   | 16b. Kind of Business/Industry<br><b>Home Improvement</b>                                      |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Frank Meredith Thwaite</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ada Lemmon Jenkins</b>   |   |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Evelyn M. Thwaite -Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>205 E. Joppa Rd. Towson, Md. 21286</b>   |   |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cem.</b>   |  | Date<br><b>April 26, 1997</b>  |   | 20c. Location - City or Town, State<br><b>Pikesville, Md.</b>                                  |   |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Eckhardt Funeral Chapel</b><br><b>11605 Reisterstown Rd., Owings Mills, Md. 21117</b>   |   |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardio pulmonary arrest</b><br>Due to (or as a consequence of):<br>b. <b>pulmonary embolism</b><br>Due to (or as a consequence of):<br>c. <b>Hx of DVT treated</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |   |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   |  |   |
| State Registrar   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |   |  |   |
|   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |   |  |   |
| 29b. Signature and title of certifier<br>   |  |  |   | 29c. License number<br><b>H 18792</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>4/24/97</b> |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Ricely DO. FACE Suite 615 Pave 6565 N Charles Towson Md 21204</b>   |  |  |   |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 25 1997</b>   |  |  |   | 32. Registrar's Signature<br>                    |  |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

2. The second part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

3. The third part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

4. The fourth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

5. The fifth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

6. The sixth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

7. The seventh part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

8. The eighth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into two columns, with names on the left and addresses on the right.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12523

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph William Tschirhart

2. Date of Death

Month Day Year  
April 20, 1997

3. Time of Death

12:00 a.m.

4a. Facility Name (If not institution, give street and number)

9551 Linville Avenue

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

154-46-4952

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 12, 1956

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9551 Linville Avenue

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Service Representative

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Louis Bernard Tschirhart

18. Mother's Name (First, Middle, Maiden Surname)

Lois Mary Forsyth

19a. Informant's Name/Relationship (Type, Print)

Laura Tschirhart/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9551 Linville Avenue, Laurel, Maryland 20723

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Baltimore Washington Cr. 4/21

Date

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each lineApproximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. LIVER FAILURE

Due to (or as a consequence of):

b. alcohol

Due to (or as a consequence of):

c. hepatitis C

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard M. Chasen, M.D.

29c. License number

D22862

29d. Date signed (Month, Day, Year)

April 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Richard M. Chasen, M.D. 14201 LAUREL PARK DRIVE LAUREL, MD. 20707

31. Date filed (Month, Day, Year)

APR 25 1997

32. Registrar's Signature

John [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Registrar or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completing filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12524

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian Louise Wood

2. Date of Death

Month Day Year  
APRIL 23 1997

3. Time of Death

12:10AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Villa Nursing Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

BALTIMORE

5. Social Security Number

578-10-3500

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG 01, 1909

9. Birthplace (State or Foreign Country)

WASH., D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

111 CHERRYDALE ROAD

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12TH GRADE

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

CHARLES QUILLAN

18. Mother's Name (First, Middle, Maiden Surname)

LOUISA TRIER

19a. Informant's Name/Relationship (Type, Print)

LOUISE PHILLIPS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 CHERRYDALE ROAD - BALTIMORE, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MEADOWRIDGE MEMORIAL PARK 4/25/97 ELKRIDGE

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Respiratory Arrest  
Due to (or as a consequence of):

b.

Cardiac Arrest  
Due to (or as a consequence of):

c.

Acute Myocardial Infarction  
Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

028236

29d. Date signed (Month, Day, Year)

4/23/97

30. Name and address of person who completed cause of death (Name, Print)

Dorcas St. Martin 5411 Old Frederick Rd Balt. Md 21229

State  
Registrar

31. Date filed (Month, Day, Year)

APR 25 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12525

Item 23a, 27, Film 746, 4/25/97, Per Med. Ex 1t

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>DAVID EDWARD YEAGER</b>  |  |   |  | 2. Date of Death<br><b>APRIL 20, 1997</b>  |  | 3. Time of Death<br><b>00:01 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>9606 CORNET COURT</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>HOWARD</b>  |  | 4c. County of Death<br><b>HOWARD</b>  |  |
| 5. Social Security Number<br><b>213-44-8721</b>   |  | 6. Sex<br><b>1 M 2 F</b>  |  | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 23, 1947</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Baltimore, Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Bel Air</b>   |  |
| 10d. Inside City Limits<br><b>1 Yes 2 No</b>  |  | 10e. Street and Number<br><b>800 Candlelight Drive</b>  |  | 10f. Zip Code<br><b>21014</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><b>1 Yes 2 No</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 Yes 2 No</b>  |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th. College (1-4 or 5+) n/a</b> |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Foreman</b> |  | 16b. Kind of Business/Industry<br><b>Bureau of Engraving &amp; Printing (Postage Stamp Div)</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Gorman Yeager</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Bedford</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Mary E. Yeager (Wife)</b>                                       |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1801 Abelia Road Fallston, Md. 21047</b> |  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Highview Mem.Cem. April 23, 1997</b>                   |  | 20c. Location - City or Town, State<br><b>Fallston, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087</b> |  |

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>   |  |  |  | Approximate Interval Between Onset and Death   |  |
| Due to (or as a consequence of):   |  |  |  |  |  |
| Due to (or as a consequence of):   |  |  |  |  |  |
| Due to (or as a consequence of):   |  |  |  |  |  |
| Due to (or as a consequence of):   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |  |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |  |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury et Work?<br><b>1 Yes 2 No</b>  |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>OCME</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 20, 1997</b>                           |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 25 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |  |

State  
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12526

Item 4c, 7 4-28-97 Film G746 W.H.Per F/H

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |  |  |  |
|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br><b>Max M. Ambach</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>25</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>10:17 AM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director                              | 5. Social Security Number<br><b>216-32-6071</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> 84 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 4, 1912</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>POLAND</b>   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>7501 PARK HEIGHTS AVE.</b>   |  | 10f. Zip Code<br><b>21208</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRANSPORTATION EXECUTIVE</b>  |  | 16b. Kind of Business/Industry<br><b>ALL STATE LEASING</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>BENJAMIN AMBACH</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>REBA UNKNOWN</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MR. BRYAN AKMAN (GRANDSON)</b>   |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8 HURLINGHAM CT. BALTIMORE, MD 21208</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HEBREW YOUNG MENS - 4-27-97</b>  |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Ellen Levine</b>  |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 Reisterstown Road Pikesville, MD 21208</b>   |  |   |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>congestive heart failure</b><br>Due to (or as a consequence of):<br><b>ischemic cardiomyopathy</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>myocardial infarction</b><br>Due to (or as a consequence of): |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>cerebral vascular Accident</b>   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| To Be Completed by<br>Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>L. Cunningham MD</b>  |  | 29c. License number<br><b>AS2402321LC9031</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/25/97</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>L. Cunningham Sinai hosp</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  |   |  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  | 33. Date of filing (Month, Day, Year)   |  |   |  |  |  |
|  | 34. State Registrar's Signature   |  | 35. Date of filing (Month, Day, Year)   |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12527

## Certificate of Death

Reg. No.

|   |   |                           |   |   |  |   |   |  |
|---|---|---------------------------|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Paul Abramson</b>                        |                           |   |   | 2. Date of Death<br>Month Day Year<br><b>April 22 1997</b>   |   | 3. Time of Death<br><b>2:49</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b> |                           |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-07-3845</b>   |                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 11, 1919</b>                                 |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                             |                           |   |   |  |   |   |  |
| Usual Residence of Decedent   |   |                           |   |   |  |   |   |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>N/A</b> |   | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br><b>3915 BROOKHILL RD.</b>   |   |                           |   | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>  |   |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BUYER</b>                   |  | 16b. Kind of Business/Industry<br><b>CLOTHING</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>MAX ABRAMSON</b>  |   |                           |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LENA GOODMAN</b>  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SHIRLEY ABRAMSON (WIFE)</b>  |   |                           |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3915 BROOKHILL RD. BALTO., MD 21215</b> |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARLINGTON (CHIZUK AMUNO)</b>   |   | Date<br><b>4/24/97</b>   |   | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>                                 |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael D. [Signature]</i>  |   |                           |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>                   |  |   |   |  |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><br>b. <b>Systemic Inflammatory Response Syndrome</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                           |   |   |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |                           |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                           |   |   |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Chronic Obstructive Pulmonary Disease,</b><br><br><b>Parkinson's Disease</b>   |   |                           |   |   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                           | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |                           | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28d. Describe how injury occurred   |   |                           |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                           |   |   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |                           |   |   |  |   |   |  |
| 29b. Signature and title of certifier<br><i>James C. Heron</i>  |   |                           |   | 29c. License number<br><b>841946</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 22, 1997</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>James C. Heron, Sinai Hospital of Baltimore</b>  |   |                           |   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |   |                           |   |   |  |   |   |  |

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours of death in the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," "accident," or "suicide" or 28d shows any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12528

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |   |  |
|--|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EUNICE AMDURS</b>  |   |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>22</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>1835</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>RANDALLTOWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-24-9925</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                             | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 20, 1929</b>                                 |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |   |   |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br><b>7920 SCOTTS LEVEL RD.</b>  |   |   |  | 10f. Zip Code<br><b>21208</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALESLADY</b>                     |  | 16b. Kind of Business/Industry<br><b>EPSTEIN'S DEPT. STORE</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>SAM AMDURS</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SHIRLEY ABRAMSON</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>HOWARD ABRAMSON (COUSIN)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5 JENNER CT. OWINGS MILLS, MD 21117</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FORBAND</b>  |  | Date<br><b>4/25/97</b>   |  | 20c. Location - City or Town, State<br><b>ROSEDALE, MD</b>                                  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Ellensue Levinson</b>   |   |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>RESPIRATORY FAILURE</b>   |   |   |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RENAL FAILURE, PNEUMONIA<br/>CHF</b>   |   |   |  |  |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |  |  |  |   |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28d. Describe how injury occurred  |  |   |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |   |  |
|  | 29b. Signature and title of certifier<br><b>R. N. L.</b>  |   |   |  | 29c. License number<br><b>D37333</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 22, 1997</b>                                |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>C. NAVI MD, NHC, BALTO. MD 21133</b>   |   |   |  |  |  |   |  |
|  | State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b> |   |  |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b> |   |  |

Baltimore, Maryland 21215-0820

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", items 23a-f or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12529

Item 2311, 27, 28abcdef Per MEO Film G747 5-20-97 Certificate of Death

Reg. No.

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ANTHONY ALSTON</b>  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 24 1997</b>   |  | 3. Time of Death<br><b>2100</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MARYLAND HOUSE OF CORRECTION</b>                                      |  | 4b. City, Town, or Location of Death<br><b>JESSUP</b>  |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-84-2913</b>  | 6. Sex<br><b>1</b> M <b>2</b> F  | 7. Age (In yrs. last birthday)<br><b>36</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>JANUARY 12, 1961</b>   | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b>   |
|  | Usual Residence of Decedent  |  |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD.</b>   | 10b. County<br><b>NA</b>   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |
|  | 10e. Street and Number<br><b>2323 DIVISION STREET</b>  |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |
|  | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>NA</b>                 |  |   |
| To Be Completed by Physician/Medical Examiner  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>                |  | 16b. Kind of Business/Industry<br><b>Housekeeping</b>  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>JAMES ALSTON</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY LOFTON</b>  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERTA BROWN: SISTER</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2119 Guilford Avenue Baltimore, Maryland 21218</b> |  |   |
|  | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MOUNT ZION Cemetery 4/30/97 Lansdowne, Maryland</b>                       |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Albert P. Wylie F/H PA<br/>638 N. Gilman St. Baltimore, MD. 21217</b>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)  |  | ASPHYXIA   |  |  |   |
| Due to (or as a consequence of):   |  | SUFFOCATION  |  |  |   |
| Due to (or as a consequence of):   |  |  |  |  |   |
| Due to (or as a consequence of):   |  |  |  |  |   |
| Due to (or as a consequence of):   |  |  |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown  |  |  |  |  |   |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No  |  |  |   |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) <b>CELL</b> |  |  |   |
| 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>4-23-97</b>   |  | 28b. Time of Injury<br><b>9:00</b> found p.m.  |   |
| 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No   |  | 28d. Describe how injury occurred<br><b>subject placed plastic bag over his head</b>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>building (prison)</b> |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Maryland House of Corrections, Jessup Maryland</b>  |  |  |  |  |   |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |  |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 24, 1997</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |   |

Baltimore, Maryland 21215-0028

permit. Pages 1 and 2 should be filled within 72 hours after death. The Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

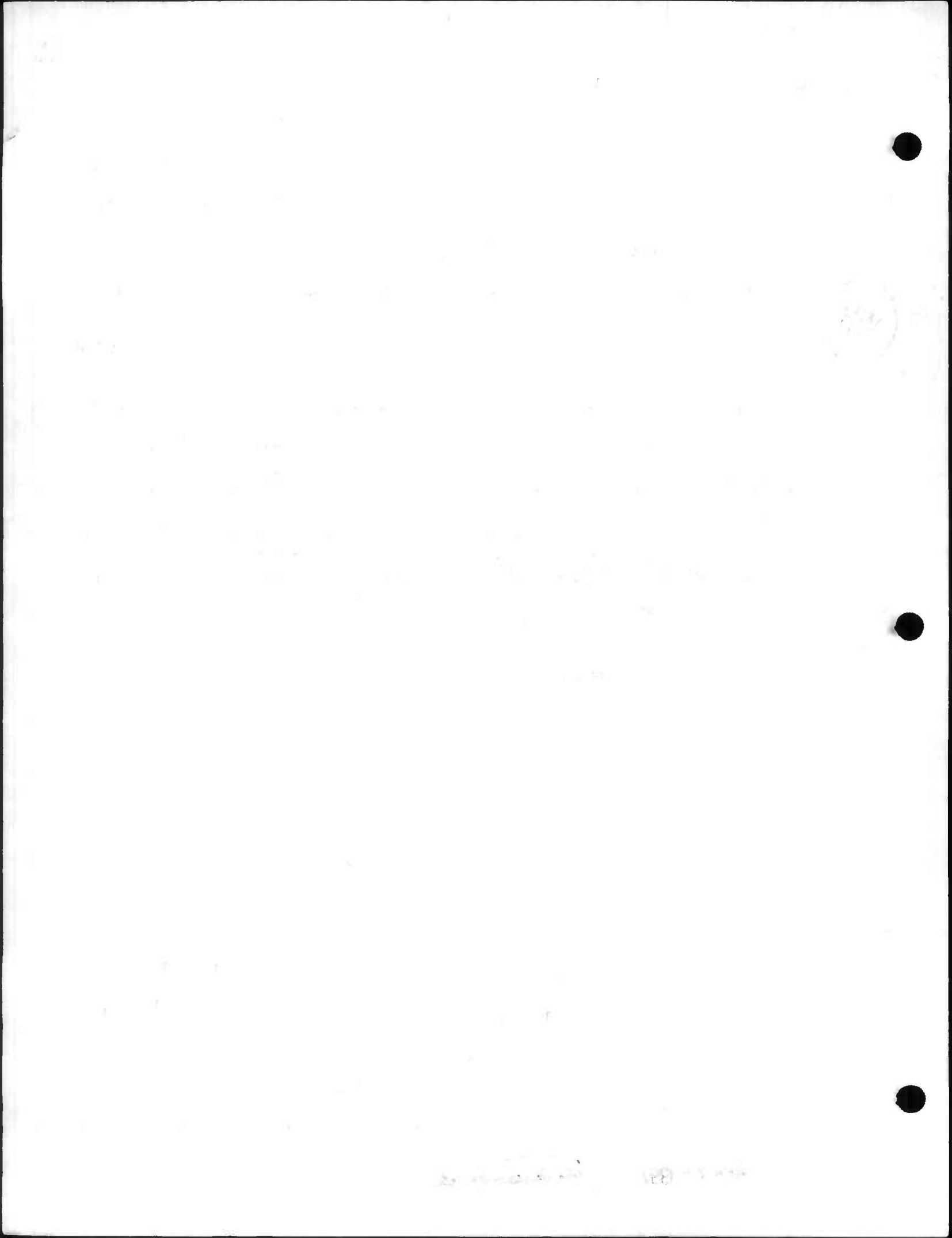
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12530

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |                                |  |   |
|--|---|--|---|--|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>JANE GLICK BACAL</b>   |  |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>20</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>9:15AM</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MERIDIAN BRIGHTWOOD NURSING HOME</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BROOKLANDVILLE</b>  |                                | 4c. County of Death<br><b>BALTIMORE</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>293-07-1229</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 28, 1919</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>OHIO</b> |
|  | Usual Residence of Decedent   |  |   |  |  |                                |  |   |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>OHIO</b>   |  | 10b. County<br><b>CUYAHOGA</b>  |  | 10c. City, Town or Location<br><b>MAYFIELD HEIGHTS</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>6811 MAYFIELD ROAD</b>   |  |   |  | 10f. Zip Code<br><b>44124</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>1</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |                                |  |   |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><b>SIDNEY GLICK</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LENA FRIEDMAN</b>  |                                |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS. SANDY BUCHMAN (DAUGHTER)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 221 BROOKLANDVILLE, MD 21022</b>  |                                |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DRUID RIDGE</b>  |  | Date<br><b>4-24-97</b>   |                                | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>                                    |   |
|  | 21. Signature of Funeral Service Licensee<br><i>Scott M. Cutler</i>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 Reisterstown Road Pikesville, MD 21208</b>   |  |  |                                |  |   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><b>Multiple Deceit</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Senile Dementia</b><br>Due to (or as a consequence of): |  |   |  |  |                                |  |   |
|  | Approximate Interval Between Onset and Death<br><b>days</b><br><b>weeks</b><br><b>years</b>   |  |   |  |  |                                |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                |  |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |                                |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |                                |  |   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                |  |   |
| State Registrar  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |                                |  |   |
|  | 29b. Signature and title of certifier<br><i>Allen M. Friedman</i>   |  | 29c. License number<br><b>D24888</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>04/20/97</b>   |                                |  |   |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Allen M. Friedman 711 W 40th St #400 Balto MD 21211</b>  |  |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>              |   | 32. Registrar's Signature<br><i>Johanna Davidson-Randall</i> |   |  |  |                                |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 28c is marked "show any injury or other traumatic event, the Medical Examiner must be notified at once."

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



## Certificate of Death

Reg. No.

|   |   |  |   |   |   |                                      |   |   |  |   |   |  |
|---|---|--|---|---|---|--------------------------------------|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>MARY R. BYRNES</u>   |  |   |   | 2. Date of Death<br>Month <u>April</u> Day <u>27</u> Year <u>1997</u>   |                                      |   |   | 3. Time of Death<br><u>10:15 AM</u>  |   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Keswick Home</u>   |  |   |   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>  |                                      |   |   | 4c. County of Death<br><u>N/A</u>  |   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>217-36-3276</u>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><u>91</u> Yrs.  |                                      | 8. Date of Birth<br>Month <u>March</u> Day <u>25</u> Year <u>1906</u> |   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>                                    |   |   |  |
|   | Usual Residence of Decedent   |  |   |   |   |                                      |   |   |  |   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><u>Maryland</u>   |  | 10b. County<br><u>N/A</u>   |   | 10c. City, Town or Location<br><u>Baltimore</u>   |                                      |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |
|   | 10e. Street and Number<br><u>700 W. 40th St.</u>  |  |   |   | 10f. Zip Code<br><u>21211</u>   |                                      | 10g. Citizen of What Country?<br><u>United States</u>                 |   |  |   |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                      |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>   |  |   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+) <u>2</u>  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Assistant Manager</u>   |                                      |   |   | 16b. Kind of Business/Industry<br><u>Real Estate</u>   |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>William Joseph Byrnes</u> John T. Mullin  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Katherine Marie Flanagan</u>  |                                      |   |   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><u>William Joseph Byrnes/Son</u><br><u>Ann M. Flynn/sister</u>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7119 Charles Spring Way</u><br><u>1000 Swarthmore Rd. Towson, MD 21204</u>                |                                      |   |   |  |   |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Greenmount Crematory</u>   |                                      |   |   | Date<br><u>4/29/97</u>   |   | 20c. Location - City or Town, State<br><u>Baltimore, Maryland</u> |  |
|   | 21. Signature of Funeral Service Licensee<br><u>John D. Mitchell IV</u>   |  |   |   | 22. Name and Address of Facility<br><u>Mitchell-Wiedefeld Home, Inc.</u><br><u>6500 York Rd.</u><br><u>Baltimore, MD 21212</u>  |                                      |   |   |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |   |                                      |   |   |  |   | Approximate Interval Between Onset and Death                      |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Chronic obstructive pulmonary disease</u><br>Due to (or as a consequence of):<br>b. <u>Parkinson's Disease</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |                                      |   |   |  |   | 5 years   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |   |   |                                      |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |   |  |
|   |   |  |   |   |   |                                      |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                      |   |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   |  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M             |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |
|   |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                      |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |   |                                      |   |   |  |   |   |  |
| 29b. Signature and title of certifier<br><u>E. Hunter Wilson M.D.</u>   |   |  |   |   |   | 29c. License number<br><u>D12487</u> |   | 29d. Date signed (Month, Day, Year)<br><u>4-27-97</u>   |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>E. HUNTER WILSON, M.D. 700 W. 40th St. BALTIMORE, MD 21211</u>   |   |  |   |   |   |                                      |   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><u>APR 28 1997</u>   |   |  |   | 32. Registrar's Signature<br><u>John Davidson-Randall</u>   |   |                                      |   |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 12 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

(11.8)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12532

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID

BROWN

2. Date of Death

Month

Day

Year

APRIL

19

1997

3. Time of Death

2:50 PM

4a. Facility Name (If not Institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

220-38-5068

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

04-23-41

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

Md.

10b. County

Na

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3413 Round Road

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Steel-worker

16b. Kind of Business/Industry

Interstate Steel

17. Father's Name (First, Middle, Last)

Bud Sloan

18. Mother's Name (First, Middle, Maiden Surname)

Hester Freeman

19a. Informant's Name/Relationship (Type, Print)

Ruth Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3413 Round Road Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forest Va Cemetery Owings Mills, Md.

Date

04-24-97

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Bilateral Pneumonia

Due to (or as a consequence of):

8 DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Nonsmall cell lung Carcinoma

Due to (or as a consequence of):

1 year

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Ioannis E. Eleftheriadis House officer

29c. License number

AS2441614-28

29d. Date signed (Month, Day, Year)

April 19 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ioannis E. Eleftheriadis M.D.

3001 S. HANOVER ST. BALTIMORE 21225

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours of death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12533

Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |  |   |
|---|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>NANCY G. CLASTER                                |   |  |  | 2. Date of Death<br>Month April 25, Day 1997 Year |  | 3. Time of Death<br>9:30 AM  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>111 Hamlet Hill Rd. #1308 |   |  |  | 4b. City, Town, or Location of Death<br>Baltimore |  | 4c. County of Death<br>N/A   |   |
| Funeral<br>Director   | 5. Social Security Number<br>220-05-0059  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>82 Yrs.  | If Under 1 Year<br>Months Days                    | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Month March 7, Day 1915 Year   | 9. Birthplace (State or Foreign Country)<br>Maryland  |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |   |
| 10a. State<br>Md.   |   | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>Baltimore   |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 10e. Street and Number<br>111 Hamlet Hill Rd. #1308   |   |   |  | 10f. Zip Code<br>21210   |   | 10g. Citizen of What Country?<br>USA   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Romper Room Teacher   |   |  | 16b. Kind of Business/Industry<br>Television   |   |
| 17. Father's Name (First, Middle, Last)<br>L. Edwin Goldman   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rita Strauss  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>John Claster (Son)  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6000 Hollins Ave. Baltimore, Md. 21210  |   |  |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.  |   | 20c. Location - City or Town, State<br>Towson, Md.   |  |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204  |   |  |  |   |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. Dehydration<br>Due to (or as a consequence of):<br>b. Bowel obstruction<br>Due to (or as a consequence of):<br>c. Recurrent Adenocarcinoma of Colon 2 1/2 years<br>Due to (or as a consequence of):<br>d.  |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br>48 hours<br>3 months<br>2 1/2 years   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|   |   |   |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br>William D. McConnell M.D.  |   |   |  | 29c. License number<br>D42129  |   | 29d. Date signed (Month, Day, Year)<br>4-25-97   |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>William D. McConnell M.D. 500 W. University Baltimore   |   |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>APR 28 1997  |   | 32. Registrar's Signature<br>Davidson-Randall   |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12534

ITEM#4c&4b PER F.H. FLM#G746 4/28/97 J.A. Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Rae Curtis

2. Date of Death

Month Day Year  
April 23, 1997

3. Time of Death

3:30 am

4a. Facility Name (If not institution, give street and number)

127 WINTERS LANE

4b. City or Town or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

218-28-3891

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

97 Yrs.

8. Date of Birth

Month Day Year  
JUL 12, 1899

9. Birthplace (State or Foreign Country)

BALTIMORE, MD

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

127 WINTERS LANE

10f. Zip Code

21228

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6 th

College (1-4 or 5+)  
-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

outside of home

17. Father's Name (First, Middle, Last)

AARON MEEKINS

18. Mother's Name (First, Middle, Maiden Surname)

SARAH CHEW

19a. Informant's Name/Relationship (Type, Print)

GWENDOLYN CURTIS - DAUGHTER- 127 WINTERS LANE, BALTIMORE, MD 21228

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify) crypt

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

4-26-97

20c. Location - City or Town, State

BALTIMORECO., MD

21. Signature of Funeral Service Licensee

*Sharon Stokes*

22. Name and Address of Facility

WM.C. MARCH FH.-4300 WABASH AVENUE

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Parkinson's disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*1 1/2 years*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*rheumatic heart disease, dementia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Timothy J. Keane, M.D.*

29c. License number

D 37458

29d. Date signed (Month, Day, Year)

4/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Timothy J. Keane, M.D. Dept Fm 29 S. Paca St. Baltimore, MD 21201*

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

*Julia Davidson-Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 28a is marked "suicide", or item 28b is marked "injury", or item 28c is marked "injury", the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12535

## Certificate of Death

Reg. No.

|   |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|---|---|------------------------------------|---|--|--|--------|---|--|---|------------------------------------|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|------------------------|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|--|--|--------|----------------------------------|--|--|--|--|--|--|----|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Marie Theresa Cook</b>   |                                    |   |  | 2. Date of Death<br>Month Day Year<br><b>April 26, 1997</b>  |        | 3. Time of Death<br><b>1:54 A.M.</b>                                    |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Martins Home</b>   |                                    |   |  | 4b. City, Town, or Location of Death<br><b>Catonsville</b>   |        | 4c. County of Death<br><b>Baltimore</b>                                 |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-46-9635</b>   |                                    | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.   |        | 8. Date of Birth (Month, Day, Year)<br><b>July 23, 1901</b>             |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|   | Usual Residence of Decedent   |                                    | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Baltimore</b>  |        | 10c. City, Town or Location<br><b>Catonsville</b>                       |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                    | 10e. Street and Number<br><b>601 Maiden Choice Lane</b>   |  | 10f. Zip Code<br><b>21228</b>  |        | 10g. Citizen of What Country?<br><b>USA</b>                             |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |        | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |                                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>                    |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles Haupke</b>  |                                    |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agatha Hummel</b>  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Msgr. Paul G. Cook/son</b>   |                                    |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>101 Church Lane Cockeysville, Md. 21030</b>  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>   |        | 20d. Date<br><b>4/29/97</b>   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |                                    |   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.</b><br><b>1050 York Road Towson, Md. 21204</b>   |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">a. <b>Congestive Heart Failure</b></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="6">b. <b>Hypertension</b></td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="6">c. <b>Atherosclerotic Cardiovascular Disease</b></td> <td>10 yrs</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="6">d.</td> <td></td> </tr> </table> |                                    |   |  |  |        |   |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Congestive Heart Failure</b> |  |  |  |  |  | Approximate Interval Between Onset and Death | Due to (or as a consequence of): |  |  |  |  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <b>Hypertension</b> |  |  |  |  |  | Due to (or as a consequence of): |  |  |  |  |  | c. <b>Atherosclerotic Cardiovascular Disease</b> |  |  |  |  |  | 10 yrs | Due to (or as a consequence of): |  |  |  |  |  |  | d. |  |  |  |  |  |  |
|   | Immediate Cause (Final disease or condition resulting in death)   | a. <b>Congestive Heart Failure</b> |   |  |  |        |   | Approximate Interval Between Onset and Death |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| Due to (or as a consequence of):  |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   | b. <b>Hypertension</b>             |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
|   |   | Due to (or as a consequence of):   |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| c. <b>Atherosclerotic Cardiovascular Disease</b>  |   |                                    |   |  |  | 10 yrs |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| Due to (or as a consequence of):  |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| d.  |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>STROKE</b>   |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| 29b. Signature and title of certifier  29c. License number <b>021649</b> 29d. Date signed (Month, Day, Year) <b>APRIL 26, 1997</b>  |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>SAMBAWAN BASKAR 3455 WILKEYS AVE BALTIMORE MD 21229</b>  |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year) <b>APR 28 1997</b> 32. Registrar Signature  |   |                                    |   |  |  |        |   |  |   |                                    |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                        |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |  |  |  |        |                                  |  |  |  |  |  |  |    |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural Cause," the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

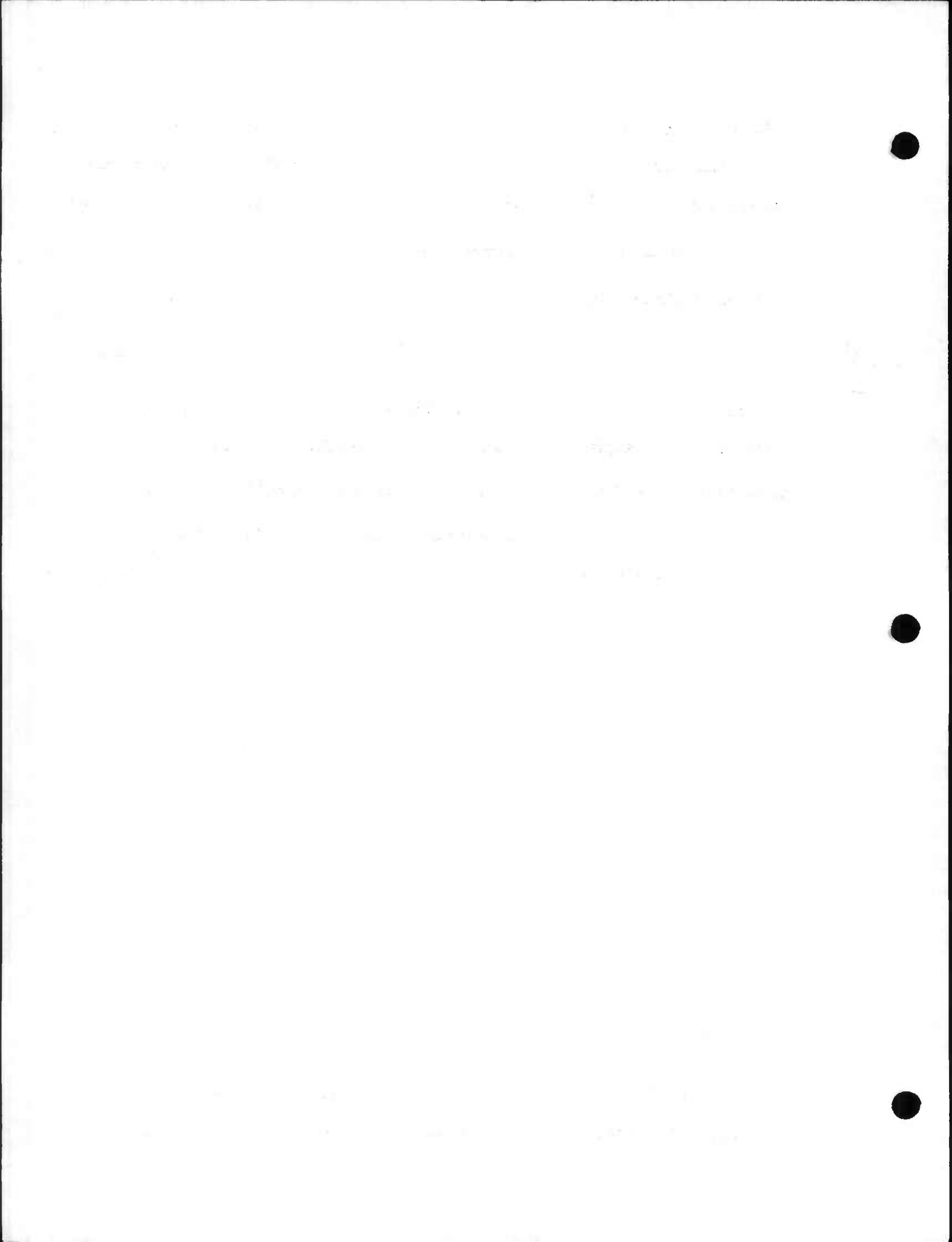
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

State  
Registrar



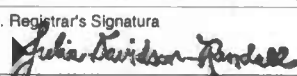
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12536

## Certificate of Death

Reg. No.

|  |   |  |   |                                |  |
|--|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH CAGLE</b>  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>26</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>5:20 am</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |                                | 4c. County of Death<br><b>BALTIMORE</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-09-9118</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 18, 1910</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>  |                                |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  | 10a. State<br><b>Md.</b>  |                                | 10b. County<br><b>Baltimore</b>  |
|  | 10c. City, Town or Location<br><b>Towson</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                |  |
|  | 10e. Street and Number<br><b>615 Chestnut Ave.</b>  |  | 10f. Zip Code<br><b>21204</b>   |                                | 10g. Citizen of What Country?<br><b>USA.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>              |                                | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Artist</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Howard Clarence Hill</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cornelia Houston Lansdale</b>   |                                |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Edward B. Cagle/husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>615 Chestnut Ave. Towson, Md. 21204</b>       |                                |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park</b>   |                                | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>   |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>                                     |                                |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Stroke - Infarct</b><br>a. Due to (or as a consequence of):<br><b>Atherosclerosis</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |  |   |                                |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   |  |   |                                |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>M</b>   |   |  |   |                                |  |
| 28b. Time of Injury<br><b>M</b>  |   |  |   |                                |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                |  |
| 28d. Describe how injury occurred  |   |  |   |                                |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |                                |  |
| 29b. Signature and title of certifier<br><b>Eugene A. O'BAH MD</b>   |   |  |   |                                |  |
| 29c. License number<br><b>044018</b>   |   |  |   |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>4/26/97</b>  |   |  |   |                                |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>EUGENE A OBAH GBMC Baltimore MD 21204</b>   |   |  |   |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |   |  |   |                                |  |
| 32. Registrar's Signature<br>   |   |  |   |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or "pending investigation", or "accident", or "suicide", or "homicide", or "other traumatic event", the Medical Examiner must be notified at once.

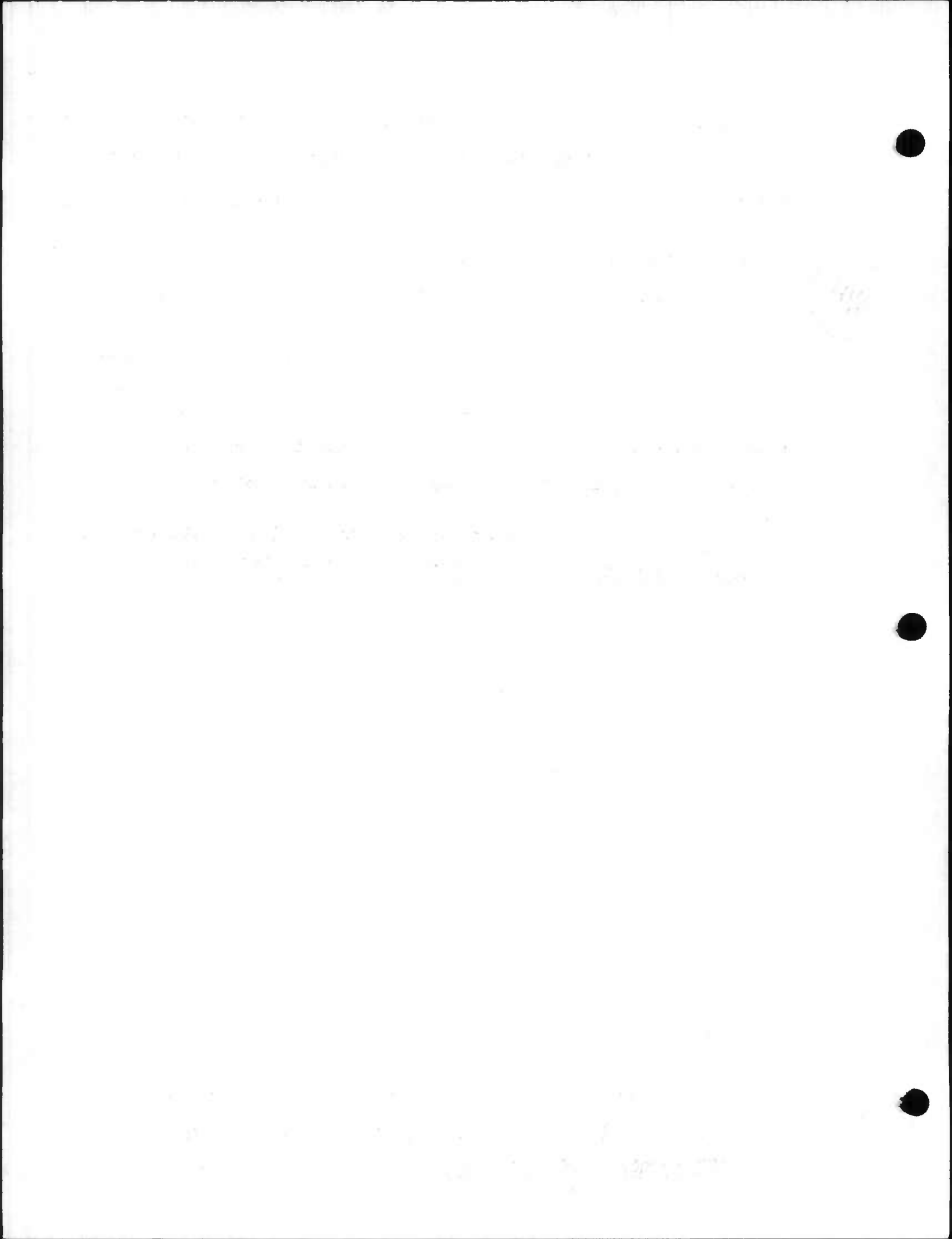
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12537

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OPAL M. CRUDDEN

2. Date of Death

April

Day

25

Year

1997

3. Time of Death

10:00 am.

4a. Facility Name (If not institution, give street and number)

Westview Villa

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-07-8093

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 8, 1911

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Stevenson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10619 Stevenson Rd.

10f. Zip Code

21153

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Legal

17. Father's Name (First, Middle, Last)

Orval Ralston Mann

18. Mother's Name (First, Middle, Maiden Summe)

Elizabeth Emma Addleman

19e. Informant's Name/Relationship (Type, Print)

William J. Crudden, Jr.-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10619 Stevenson Rd. Stevenson, Md. 21153

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cem. April 28, 1997 Pikesville, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. S. Eshelb

22. Name and Address of Facility

Eckhardt Funeral Chapel  
11605 Reisterstown Rd. Owings Mills, Md.

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edmund C. Thorne

29c. License number

D34951

29d. Date signed (Month, Day, Year)

4-26-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Edmund C. Thorne 405 Frederick Rd Suite 100 Catonsville MD 21048

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12538

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHNNIE

CALDWELL SENIOR

2. Date of Death

Month  
APRILDay  
19Year  
1997

3. Time of Death

10:56 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

216-32-0583

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
03-31-36

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

Md

10b. County

Na

10c. City, Town or Location

Baltimore

10d. Inside City Limits

Yes 2 No

10e. Street and Number

813 Bonaparte Avenue

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
Yes 2 No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th Grade

College (14 or 5+)

Na

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Federal Policeman

16b. Kind of Business/Industry

S.S. Administration

17. Father's Name (First, Middle, Last)

James Caldwell

18. Mother's Name (First, Middle, Maiden Surname)

Easter Boyles

19a. Informant's Name/Relationship (Type, Print)

Mary Brake

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

951 Austin Avenue Aurora, ILL. 60507-1824

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest VA Cem. 04-25-97 Owings Mills, Md.

Date

20c. Location - City or Town, State

Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Md. 21202  
WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MASSIVE HEMOPTYSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 HOUR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ABDOMINAL ANEURYSM; HISTORY OF BYPASS; SEVERE

PERIPHERAL VASCULAR DISEASE; PNEUMOTHORAX;

SEIZURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D2347

29d. Date signed (Month, Day, Year)

4/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Moshonah Annous, 3007 E. North Pkwy 21214

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0001  
permit. Pages 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12539

Items: 23 part I, 27 per ME0 G-747 5/1/97 reb

Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |
|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>SHAHID COLEMAN</b>   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 20, 1997</b>   |  | 3. Time of Death<br><b>10:41AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HOPKINS-BAYVIEW HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>NA</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>Unknown</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs. Months Days<br><b>4 10</b>   | 8. Date of Birth (Month, Day, Year)<br><b>12-10-96</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>   | 10b. County<br><b>NA</b>   | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   | 10e. Street and Number<br><b>5503 Odella Ave.</b>   |  | 10f. Zip Code<br><b>21204</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Child</b> College (1-4 or 5+) <b>NA</b>         |  |  |  |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Child</b>   |  | 16b. Kind of Business/Industry<br><b>Child</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pennie S. Coleman</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Myra Taylor</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3007 E. Biddle St., Balto., MD 21213</b>      |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Uashell mem Gardens</b>  |  | 20c. Location - City or Town, State<br><b>4-25-97 Dundalk, MD</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>March F. H. East 1101 E. North Ave</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SUDDEN INFANT DEATH SYNDROME</b>  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year)   |  |   |  |  |  |
|   | 28b. Time of Injury<br><b>M</b>   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
|   | 28d. Describe how injury occurred   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br>   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>O.C.M.E.</b>  |  |   |  |  |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 21, 1997</b>  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. L. LORON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br>   |  |   |  |  |  |
|   | 33. Registrar's Name<br><b>John Davidson-Randall</b>  |  |   |  |  |  |

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death. The Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", items 33a or 33b show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12540

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARJORIE

CAUFFMAN

2. Date of Death

APRIL

24 1997

3. Time of Death

3:58pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

166-16-5783

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 5, 1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

212 Bertram Circle

10f. Zip Code

21060

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank MacAfee

18. Mother's Name (First, Middle, Maiden Surname)

Sophie Januszewski

19a. Informant's Name/Relationship (Type, Print)

Charles T. Cauffman / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

212 Bertram Circle, Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Crownsville MD Vet. Cem.

Date

April  
28, 1997

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home, P.A.  
421 Crain Hwy., S.E., Glen Burnie, MD 2106123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Acute Myocardial Infarction

2 hrs.

b. Due to (or as a consequence of):

Angina Pectoris

1 yr.

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ POA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

795 Ravachant Rd, Glen Burnie, MD.

31. Date filed (Month, Day, Year)

APR 28 1997

Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12541

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |   |  |  |
|---|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOAN MARIE COFIELL</b>                   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>April 23, 1997</b>  |   | 3. Time of Death<br><b>3:15am</b>                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>606 Hollow Rd.</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Ellicott City</b> |   | 4c. County of Death<br><b>Baltimore Co.</b>            |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-40-4289</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.             |   | 8. Date of Birth (Month, Day, Year)<br><b>7/6/1944</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>                                  |  | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>Baltimore</b>                              |   | 10c. City, Town or Location<br><b>Ellicott City</b>    |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>606 Hollow Road</b>   |  | 10f. Zip Code<br><b>21043</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>materials specialist</b>   |  | 16b. Kind of Business/Industry<br><b>PEPCO Electric</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>John Wesley MacKenzie</b>   |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Doris Marguerite Mansfield</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Farley Y. Cofiehl (husb)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>606 Hollow Rd., Ellicott City, MD. 21043</b>   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Crematory</b>  |   | 20c. Date<br><b>4/24/97</b>  |  | 20d. Location - City or Town, State<br><b>Hampstead, MD.</b>   |  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |  |
| 22. Name and Address of Facility<br><b>Witzke Funeral Homes, Inc. 21228<br/>1630 Edmondson Ave., Catonsville, Md.</b>   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metastatic breast cancer</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>3 yrs</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |   | 29c. License number<br><b>D18587</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 23 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAUL GORMLEY 900 CATON AVE BAZZO MD 21229</b>  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  | 33. State Registrar  |  | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0820   |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0820

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be kept for 24 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12542

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |   |   |  |   |  |   |  |  |
|--|---|--|---|--|---|---|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH DUMLER</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>25</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>10:35AM</b>                                      |  |   |  |   |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>VA Maryland Health Care System</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Perry Point</b>  |   | 4c. County of Death<br><b>Cecil</b>                                     |  |   |  |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-03-4684</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Days  | 8. Date of Birth (Month, Day, Year)<br><b>June 22, 1915</b>             | 9. Birthplace (State or Foreign Country)<br><b>Md.</b> |   |  |   |  |  |
|  | Usual Residence of Decedent   |  |   |  | 10a. State<br><b>Md.</b>  |   | 10b. County<br><b>Baltimore</b>   |  |   |  |   |  |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |   | 10e. Street and Number<br><b>2718 Placid Ave.</b>                       |  |   |  |   |  |  |
|  | 10f. Zip Code<br><b>21234</b>   |  |   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |   |  |   |  |   |  |  |
|  | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: <b>WW-II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |  |   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Shipping Dept.</b>                |   | 16b. Kind of Business/Industry<br><b>Esskay Meat Co.</b>                |  |   |  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph J. Dumler, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna L. Trost</b>   |   |   |  |   |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Annette M. Dumler/wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2718 Placid Ave. Baltimore, Md. 21234</b>     |   |   |  |   |  |   |  |  |
|  | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify) <b>Entombment</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem.</b>                |  | Date<br><b>4/29/97</b>  |   | 20c. Location - City or Town, State<br><b>Timonium, Md.</b>             |  |   |  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.</b><br><b>1050 York Rd. Towson, Md. 21204</b>                               |   |   |  |   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |   |   |  |   |  |   |  |  |
|  | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Sepsis</b><br/>Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>one week</b> </td> </tr> <tr> <td>b. _____<br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____<br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____<br/>Due to (or as a consequence of):</td> </tr> </table> |  |   |  |   |   |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <b>Sepsis</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br><b>one week</b> | b. _____<br>Due to (or as a consequence of): | c. _____<br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | a. <b>Sepsis</b><br>Due to (or as a consequence of):  | Approximate Interval Between Onset and Death<br><br><b>one week</b>  |   |  |   |   |   |  |   |  |   |  |  |
|  | b. _____<br>Due to (or as a consequence of):  |  |   |  |   |   |   |  |   |  |   |  |  |
|  | c. _____<br>Due to (or as a consequence of):  |  |   |  |   |   |   |  |   |  |   |  |  |
|  | d. _____<br>Due to (or as a consequence of):  |  |   |  |   |   |   |  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's disease</b>   |   |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |   |  |   |  |   |  |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |   |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No               |   |  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |   |  |   |   |   |  |   |  |   |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |   |  |   |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   | 28d. Describe how injury occurred  |   |   |   |  |   |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |   |   |   |  |   |  |   |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |   |   |   |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br>   |   |  |   | 29c. License number<br><b>D31198</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 25, 1997</b>  |   |  |   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SMITTA KITTUR, M.D., Perry Point, Maryland 21902</b>  |   |  |   |  |   |   |   |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |   |  |   | 32. Registrar's Signature<br> |   |   |   |  |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 24 hours of death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

HW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12543

ITEM#4 PER F.H. FLM#G748 6/24.97 J.A.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **WENDY LYNNE DIACOLOUKAS**

2. Date of Death Month **APRIL** Day **24** Year **1997**

3. Time of Death **08:50PM**

Funeral  
Director

4a. Facility Name (If not institution, give street and number) **GREATER BALTIMORE MEDICAL CENTER**

4b. City, Town, or Location of Death **TOWSON**

4c. County of Death **BALTIMORE**

5. Social Security Number **214-94-2028**

6. Sex ☐ M ☒ F

7. Age (In yrs. last birthday) **25** Yrs.

8. Date of Birth (Month, Day, Year) **Sept. 04, 1971**

9. Birthplace (State or Foreign Country) **Baltimore, Md.**

Usual Residence of Decedent

10a. State **Maryland**

10b. County **Harford Co.**

10c. City, Town or Location **Bel Air**

10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **1107 Milchling Drive**

10f. Zip Code **21015**

10g. Citizen of What Country? **United States**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12) 11** **College (1-4or 5+)**

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Home Maker**

16b. Kind of Business/Industry **Own Home**

17. Father's Name (First, Middle, Last) **David Edward Bury**

18. Mother's Name (First, Middle, Maiden Surname) **Maria Michelle Long**

19a. Informant's Name/Relationship (Type, Print) **Mr. Nicholas G. Diacoloukas (Hus.)**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **1107 Milchling Drive Bel Air, Md. 21015**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) **Oak Lawn Cemetery**

20c. Location - City or Town, State **4/28/97 Baltimore Co. Md.**

21. Signature of Funeral Service Licensee **Jeffrey L. Gair**

22. Name and Address of Facility **Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204**

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) **Cervical Cancer, mets.**

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death **7 2 yrs.**

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No

26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury **M**

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **G. J. W. M. D.**

29c. License number **D27730**

29d. Date signed (Month, Day, Year) **4/25/97**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **GARY L. W. M. D. 6169 N. CHARLES ST. BALTIMORE MD 21204**

31. Date filed (Month, Day, Year) **APR 28 1997**

32. Registrar's Signature **Julia Davidson-Randall**

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12544

Items: 9,19a per Informant G-749 7/8/97 reb

Certificate of Death

Reg. No.

|  |  |   |  |  |   |   |  |  |
|--|--|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ANNIE DASHIELL</b>                                |   |  |  | 2. Date of Death<br>Month <b>4</b> Day <b>22</b> Year <b>97</b> |   | 3. Time of Death<br><b>8:15 P</b>                            |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Union Memorial Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>        |   | 4c. County of Death<br><b>Baltimore City</b>                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-22-5857</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.                |   | 8. Date of Birth (Month, Day, Year)<br><b>March 23, 1912</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>ARKANSAS</b>                                      |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore City</b>                            |   | 10c. City, Town or Location<br><b>Baltimore</b>              |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>8</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Social Worker</b>   |  | 16b. Kind of Business/Industry<br><b>public school</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>William Louis Currie</b>  |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Elva Holland</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Annie Carusi/daughter</b><br><b>Clara Anne Dashiell Carusi</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7275 Swan Point Way, Columbia, Maryland 21045</b>  |   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph B. Van Sant</b>   |  | 22. Name and Address of Facility<br><b>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland 21201</b>   |  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute Pulmonary Embolism</b> |   | Approximate Interval Between Onset and Death<br><b>25 MIN</b>   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year)<br><b>4/23/97</b>   |   | 28b. Time of Injury<br><b>11</b>  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Gregory J. Stalker MD</b>   |  | 29c. License number<br><b>D25662</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/23/97</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>3333 N. CALVERT ST 21218</b>  |  | 31. Data filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  | 32. Registrar's Signature<br><b>John Davidson-Rendell</b>  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12545

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD

DORSEY

2. Date of Death

Month  
APRILDay  
21Year  
1997

3. Time of Death

5:58 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris At Mercy Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

213-72-9613

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12-29-58

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

333 East 28th Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

Collage (1-4 or 5+)

Na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Personel Asst. to Univ. President Univ.

16b. Kind of Business/Industry

Johns Hopkins

Univ.

17. Father's Name (First, Middle, Last)

Charles W. Dorsey, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna Banks

19a. Informant's Name/Relationship (Type, Print)

Anna Dorsey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218

333 East 28th Street Street Baltimore, Md.

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Mem. Pk. Cem 04-26-97 Randallstown, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACQUIRED IMMUNE DEFICIENCY SYNDROME

~ 5 years

Due to (or as a consequence of):

b. HIV INFECTION

UNKNOWN

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) STELLA MARIS AT MERCY

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDO J. FERRO, MD

5810 BELAIR RD  
BALTO., MD 21206

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death. Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or if item 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12546

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE EVANGELOS DEDOULIS

2. Date of Death

Month Day Year  
APRIL 22, 1997

3. Time of Death

6:10 AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-32-8506

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 20, 1928

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1020 Marksworth Road

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Navar Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanical Engineer

16b. Kind of Business/Industry

Consulting Firm

17. Father's Name (First, Middle, Last)

Evangelos Dedoulis

18. Mother's Name (First, Middle, Maiden Surname)

Anthoula Hagis

19a. Informant's Name/Relationship (Type, Print)

Christine Dedoulis (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1020 Marksworth Road Catonsville, Maryland 21228

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greek Orthodox Cemetery April

Date

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.  
1630 Edmondson Avenue Catonsville, Maryland 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. METASTATIC PROSTATE CANCER  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

3 mos.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SUPRAVENTRICULAR TACHYCARDIA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicidal ☐ Homicidal28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.T. IMPERIAL JR - 900 Caton Ave.

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12547

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Douglas Ellwood

2. Date of Death

April 26 1997

3. Time of Death

5:25 PM

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

212 26 9675

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 13, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Upper Falls

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11215 Raphael Rd.

10f. Zip Code

21156

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Printer

16b. Kind of Business/Industry

Washington State Gov't

17. Father's Name (First, Middle, Last)

Leo

Ellwood

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude

Isenrock

19a. Informant's Name/Relationship (Type, Print)

Susan K. Ellwood / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11215 Raphael Rd., Upper Falls, MD 21156

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 4/29/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

*Stephen D. Lohrmann*

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.  
8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *encephalitis*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*4 months*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*David S. Down*

29c. License number

*P32259*

29d. Date signed (Month, Day, Year)

*April 27, 1997*

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

*David S. Down* *615 W. MacPhar.*

31. Date filed (Month, Day, Year)

**APR 28 1997**

32. Registrar's Signature

*J. Davidson-Randall*

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0030

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" cause, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

152

152

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12548

|  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>SCOTT KARL EDWARDS   |  |  |  | 2. Date of Death<br>Month Day Year<br>APRIL 20, 1997   |  | 3. Time of Death<br>10:25 AM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>3911 SWEET AIR ROAD-ST. JOHNS CHURCH   |  |  |  | 4b. City, Town, or Location of Death<br>Phoenix  |  | 4c. County of Death<br>BALTIMORE  |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-68-1049   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>26 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Sept 11, 1970  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>Maryland   |  | 10b. County<br>Baltimore   |  | 10c. City, Town or Location<br>Timonium   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>315 Gailridge Road   |  | 10f. Zip Code<br>21093   |  | 10g. Citizen of What Country?<br>USA  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1987-1992  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                |  |
| To Be Completed by Physician/Medical Examiner                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Paving Mechanic   |  | 16b. Kind of Business/Industry<br>Paving   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Donald George Edwards   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Marilyn Louise Miller   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Donald G. Edwards/Father   |  |   |  |
| Physician<br>/Medical<br>Examiner  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>315 Gailridge Road, Timonium, MD 21093  |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Carroll Cremation Service  |  | 20c. Location - City or Town, State<br>Hampstead, Maryland                                      |  |
|  | 21. Signature of Funeral Service Licensee<br>Bryan W. Clary  |  | 22. Name and Address of Facility<br>Lemmon Funeral Home<br>10 W. Padonia Road, Timonium, MD 21093  |  | 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Contact Shotgun Wound of Head<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |
| State<br>Registrar   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |
|  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) IN CAR |  |  |  |   |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month Day Year)<br>UNK  |  | 28b. Time of Injury<br>UNK M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner         | 28d. Describe how injury occurred<br>Subject shot self   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Parking lot  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>3911 Sweet Air Rd 21131  |  |   |  |
|  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>[Signature]   |  | 29c. License number<br>O.C.M.E   |  | 29d. Date signed (Month, Day, Year)<br>APRIL 21, 1997   |  |
| To Be Completed by Physician/Medical Examiner                                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201  |  |  |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br>APR 28 1997   |  | 32. Registrar's Signature<br>[Signature]   |  |  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

97 12549

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE ERNEST EISENHUT

2. Date of Death

Month Day Year  
APRIL 26, 1997

3. Time of Death

3:30 P.M.

4a. Facility Name (If not institution, give street and number)

11918 Thurloe Drive

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-24-6743

6. Sex

M 2 ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 21, 1929

9. Birthplace (State or Foreign Country)

Baltimore City

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11918 Thurloe Drive

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Property Manager

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Ernest Eisenhut

18. Mother's Name (First, Middle, Maiden Surname)

Ida Karceski

19a. Informant's Name/Relationship (Type, Print)

Carolyn F. Eisenhut - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11918 Thurloe Drive, Timonium, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gardens

Date

April 30, 1997

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

VICTOR LENGAND, JR.

22. Name and Address of Facility

LEMMON FUNERAL HOME OF DULANEY VALLEY, INC.  
10 W. PADONIA RD., TIMONIUM, MD. 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Arteriosclerotic Cardiovascular Disease*  
Dua to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.   
Dua to (or as a consequence of):c.   
Dua to (or as a consequence of):d.   
Dua to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles F. Donnell MD - 111 Hamlet Hill Rd Baltimore MD 21218

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

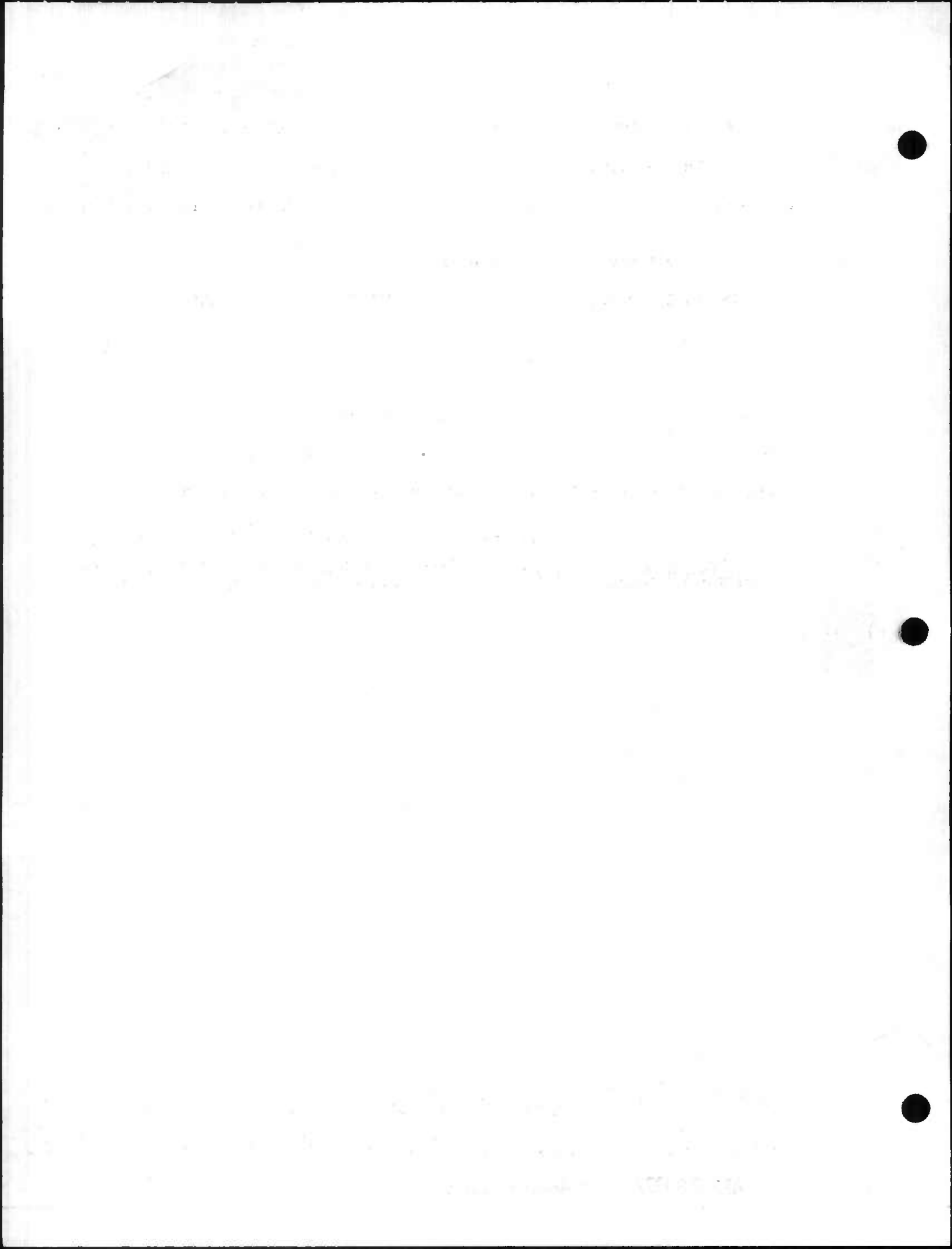
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020. The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12550

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDMONIA EANES

2. Date of Death

April 26, 1997 12:45

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital Baltimore

4b. City, Town, or Location of Death

4c. County of Death

City

5. Social Security Number

220-22-3263

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 8, 1913

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10a. State

MD.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4117 Crest Heights Road

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Housekeeping

17. Father's Name (First, Middle, Last)

Tom Scott

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Scott

19a. Informant's Name/Relationship (Type, Print)

Dorothy J. Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4117 Crest Heights Road Baltimore, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Cemetery 5-297 Baltimore, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Albany P. Wylie 3/H PA  
638 N. Gilman Street Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

29c. License number

89264

29d. Date signed (Month, Day, Year)

April 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN Schwartz, M.D. c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarBaltimore, Maryland 21245-0020  
permit. Pages 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked "pending", "natural", or "homicide", or items 23a or 28a-4 show any injury or other traumatic event, a Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1000

1000

1000

1000

1000

1000

1000

1000

1000

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State of Maryland / Department of Health and Mental Hygiene

97 12551

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES

EHRIG

2. Date of Death  
Month Day Year

April

24

1997

3. Time of Death

23:30

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-18-2007

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
October 7, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8408 Hallmark Circle

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bank Examiner

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Gustav A. Ehrig

18. Mother's Name (First, Middle, Maiden Surname)

Pauline L. Schneider

19a. Informant's Name/Relationship (Type, Print)

Mrs. Dorothy Ehrig / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8408 Hallmark Circle Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parkwood Cemetery

Date

4/28/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee Milton J Knight Jr

Milton J Knight Jr

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause of each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Melanoma - Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Adriana Andradec, MD

29c. License number

P10579

29d. Date signed (Month, Day, Year)

April 24, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Good Samaritan Hospital, 5601 Loch Raven Boulevard Baltimore, MD

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", pages 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
office.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12552

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |   |  |  |  |
|--|--|---|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William A. Eggert Jr</b>                          |   |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>27</b> Year <b>1997</b> |   | 3. Time of Death<br><b>02:30</b>                           |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |   | 4c. County of Death<br><b>NA</b>                           |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-01-5824</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 6, 1918</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                      |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>  |   | 10c. City, Town or Location<br><b>BALTO MARYLAND</b>       |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>4113 CENTURY Rd</b>   |   | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>N/A</b>  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CARPENTER</b>  |  | 16b. Kind of Business/Industry<br><b>WOOD Wkg Co.</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>William A. Eggert SR</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROSE PRUCHNIEWSKI</b>   |  | 19. Informant's Name/Relationship (Type, Print)<br><b>DORIS W Eggert</b>   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARKWOOD</b>   |  | 20c. Location - City or Town, State<br><b>4/29/97 BALTIMORE</b>  |   | 21. Signature of Funeral Service Licensee<br><b>Judy D. Smith</b>   |  | 22. Name and Address of Facility<br><b>HARTLEY MILLER FUNERAL HOME<br/>7527 HARFORD Rd BALTO MD 21234</b>  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>renal failure</b><br>Due to (or as a consequence of):<br>c. <b>renal cell carcinoma</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>one week</b><br><b>one month</b><br><b>one year</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                          |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. Signature and title of certifier<br><b>Stuart M. Lubinski physician</b>   |  | 29c. License number<br><b>D50096</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 27, 1997</b>   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stuart M. Lubinski Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore MD</b> |  | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |   | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12553

## Certificate of Death

Reg. No.

|   |  |   |   |  |   |  |  |  |
|---|--|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM RAYMOND FOSTER</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 24 1997</b>  |  | 3. Time of Death<br><b>8:57 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1504 SULFUR SPRING ROAD (REAR)</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>ARBUTUS</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-50-9620</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>April 3, 1948</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  |
|   | Usual Residence of Decedent  |   |   |  |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br><b>5716 Oakland Road</b>   |   |   | 10f. Zip Code<br><b>21227</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>                     |  | 16b. Kind of Business/Industry<br><b>Construction</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Paul Foster</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen McGuire</b>  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Paul Foster/Father</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5716 Oakland Road Baltimore, Md. 21227</b> |   |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Crematory</b>  |  | Date<br><b>4-26-97</b>  | 20c. Location - City or Town, State<br><b>Brentwood, Md.</b>                                   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   | 22. Name and Address of Facility<br><b>Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Md. 21229</b>                                     |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cirrhosis</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 25, 1997</b>                                   |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  | 32. Registrar's Signature<br>  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "Natural," or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12554

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><u>Joan Fromme</u>  |  | 2. Date of Death<br>Month <u>APRIL</u> Day <u>24</u> Year <u>1997</u>   |  | 3. Time of Death<br><u>02:30AM</u>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><u>THE JOHNS HOPKINS HOSPITAL</u>   |  | 4b. City, Town, or Location of Death<br><u>BALTIMORE CITY</u>   |  | 4c. County of Death<br><u>N/A</u>   |  |
| 5. Social Security Number<br><u>192-30-4621</u>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>60</u> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><u>Feb. 4, 1937</u>  |  | 9. Birthplace (State or Foreign Country)<br><u>Pennsylvania</u>   |  |   |  |
| 10a. State<br><u>PA</u>   |  | 10b. County<br><u>Lancaster</u>   |  | 10c. City, Town or Location<br><u>Upper Leacock Twp</u>   |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><u>38 N. Maple Ave.</u>   |  | 10f. Zip Code<br><u>17540</u>   |  |
| 10g. Citizen of What Country?<br><u>USA</u>   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Secretary</u>   |  | 16b. Kind of Business/Industry<br><u>Dept. of Defense</u>   |  |
| 17. Father's Name (First, Middle, Last)<br><u>Arthur Jenkins</u>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Bessie Adams</u>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>David J. Fromme</u>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>38 N. Maple Ave., Leola, PA 17540</u>   |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Green Mount Crematory</u>  |  | 20c. Location - City or Town, State<br><u>4/25/97 Baltimore, MD</u>   |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>   |  | 22. Name and Address of Facility<br><u>ALTENBURG FUNERAL HOME, P.A.</u><br><u>6009 Harford Rd., Baltimore, MD 21214</u>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>Invasive Fungal Sinusitis</u><br>Dua to (or as a consequence of):<br><br>b. <u>Felty's Syndrome</u><br>Dua to (or as a consequence of):<br><br>c. <u>Rheumatoid Arthritis</u><br>Dua to (or as a consequence of):<br><br>d. <u></u> |  | Approximate Interval Between Onset and Death<br><br><u>1 month</u><br><br><u>1-2 years</u><br><br><u>years</u>  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br><u></u>  |  | 28b. Time of Injury<br><u>M</u>   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><u></u>  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><u></u>   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><u></u>   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u><br><u>Stephen B. Gruber, M.D., Ph.D.</u>  |  | 29c. License number<br><u>M5760</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>April 24, 1997</u>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Stephen B. Gruber, M.D., Ph.D. Johns Hopkins Oncology Center 600 N. Wolfe St., Baltimore, MD 21287</u>   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><u>APR 28 1997</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21201-0000  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 00000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12555

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>CATHERINE ISABEL FRINGER</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 24 1997</b>   |  |  |  | 3. Time of Death<br><b>5:35 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Williamsport Nursing Home</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Williamsport</b>  |  |  |  | 4c. County of Death<br><b>Washington</b>   |  |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>230-15-2952</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>79</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 9, 1917</b>                      |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director                     | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Williamsport</b>   |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number<br><b>16730 Tammany Road</b>   |   |   |  | 10f. Zip Code<br><b>21795</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>          |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>0</b>  |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>homemaker</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>her own home</b>                            |  |  |  |
| To Be Completed by Physician/Medical Examiner           | 17. Father's Name (First, Middle, Last)<br><b>Owen H. Mills</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maggie Flora unknown</b>   |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Walter R. Fringer</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16730 Tammany Road, Williamsport, Md. 21795</b>  |  |  |  |  |  |
|   | 20a. Method of Disposition & removal in state<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garden of Faith Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Co. Md.</b>                 |  | 20d. Date<br><b>4/28/97</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |  | 22. Name and Address of Facility<br><b>MINNICH FUNERAL HOME</b><br><b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner                       | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br>c. <b>ASPIRATION</b><br>Due to (or as a consequence of):<br>d. <b>CEREBROVASCULAR ACCIDENT</b> |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>2 DAYS.</b><br><b>2 WEEKS</b><br><b>3 WEEKS</b><br><b>3 WEEKS</b>   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEIZURE DISORDER</b>   |   |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |   |   |   |  |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |   |   |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner           | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |  |  |  |  |  |
| State Registrar   | 29b. Signature and title of certifier<br><i>[Signature]</i> <b>ZAFAR MALIK MD</b>   |   |   |  | 29c. License number<br><b>044996</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 25, 1997</b>                     |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ZAFAR MALIK MD 20311 LAPPANS RD BOWERSBRO MD 21713</b>   |   |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b> |   | 32. Registrar's Signature<br><i>[Signature]</i> |   |  |  |  |  |  |  |  |

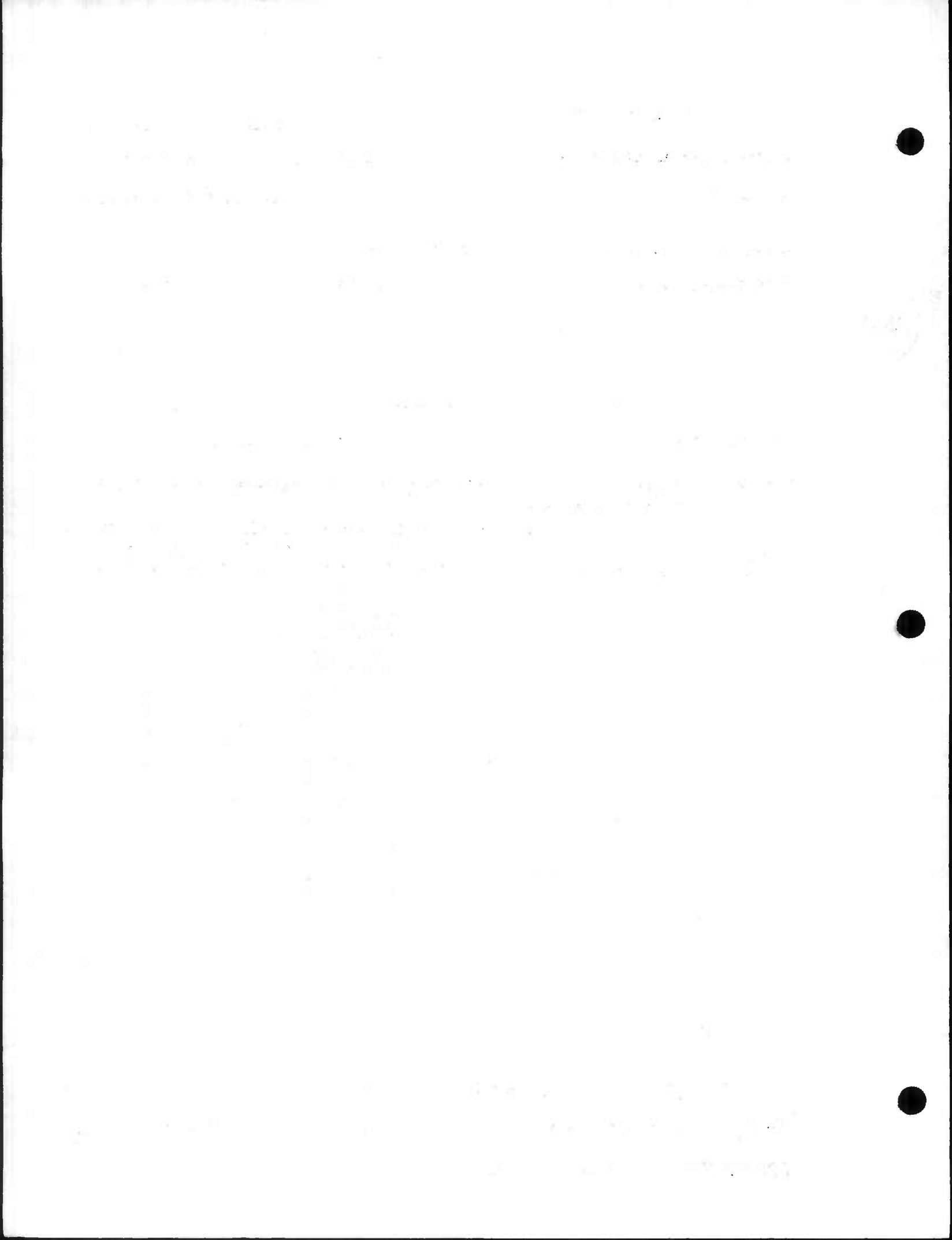
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12556

Item 1 4-28-97 Film G746 W.H.Per Doctor

## Certificate of Death

Reg. No.

|  |  |                                 |   |  |  |   |   |  |
|--|--|---------------------------------|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last) <u>Thelma Evelyn FARLEY</u>   |                                 |   |  | 2. Date of Death<br>Month <u>APRIL</u> Day <u>23</u> Year <u>1997</u>  |   | 3. Time of Death<br><u>12:00 Noon</u>                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>GENESIS CATONSVILLE COMMONS</u>   |                                 |   |  | 4b. City, Town, or Location of Death<br><u>BALTIMORE</u>   |   | 4c. County of Death<br><u>BALTIMORE</u>                                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>577-01-1740</u>  | 6. Sex<br><u>1</u> M <u>2</u> F | 7. Age (In yrs. last birthday)<br><u>94</u> Yrs.  | If Under 1 Year<br>Months Days                                 | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><u>Feb. 21, 1903</u> |   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>  |
|  | Usual Residence of Decedent  |                                 |   |  |  |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><u>Maryland</u>  |                                 | 10b. County<br><u>N/A</u>   |  | 10c. City, Town or Location<br><u>Baltimore</u>  |   | 10d. Inside City Limits<br><u>XX</u> Yes <u>2</u> No                    |  |
|  | 10e. Street and Number<br><u>4709 Dartford Avenue</u>  |                                 |   |  | 10f. Zip Code<br><u>21229</u>  |   | 10g. Citizen of What Country?<br><u>U.S.A.</u>                          |  |
|  | 11. Marital Status<br><u>1</u> Never Married <u>2</u> Married<br><u>3</u> Widowed <u>4</u> Divorced  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><u>1</u> Yes <u>2</u> No<br>If Yes, Give Year or Dates:                        |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> Yes <u>2</u> No Specify:      |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>7</u> College (1-4 or 5+) <u>College (1-4 or 5+)</u>   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Homemaker</u> |  | 16b. Kind of Business/Industry<br><u>Own Home</u>  |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><u>(Unknown) Price</u>  |                                 |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Sarah (Unknown)</u>  |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Joan Farley (Daughter)</u>  |                                 |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>4709 Dartford Avenue Baltimore, Maryland 21229</u> |   |   |  |
|  | 20a. Method of Disposition<br><u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State<br><u>4</u> Donation <u>5</u> Other (Specify)   |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Baltimore National</u>                           |  | Date<br><u>April 25, 1997</u>  |   | 20c. Location - City or Town, State<br><u>Baltimore, Maryland</u>       |  |
|  | 21. Signature of Funeral Service Licensee<br><u>R. C. [Signature]</u>  |                                 |   |  | 22. Name and Address of Facility<br><u>Witzke Funeral Home of Catonsville, Inc.<br/>1630 Edmondson Avenue Catonsville Maryland 21228</u>               |   |   |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not omit the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |                                 |   |  |  |   |   | Approximate Interval Between Onset and Death   |
|  | Immediate Cause (Final disease or condition resulting in death)<br><u>CEREBRAL HEMORRHAGE</u>  |                                 |   |  |  |   |   | <u>19 days</u>   |
|  | Due to (or as a consequence of):<br><u>HYPERTENSION</u>  |                                 |   |  |  |   |   | <u>years</u>   |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   |                                 |   |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><u>HYPOTHYROIDISM</u>  |                                 |   |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown  |
|  | 24a. Was an autopsy performed?<br><u>1</u> Yes <u>2</u> No   |                                 |   |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><u>1</u> Yes <u>2</u> No  |
|  | 25. Was case referred to medical examiner?<br><u>1</u> Yes <u>2</u> No   |                                 |   |  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) |
|  | 27. Manner of Death<br><u>1</u> Natural <u>5</u> Pending Investigation<br><u>2</u> Accident <u>6</u> Could not be determined<br><u>3</u> Suicide <u>4</u> Homicide                                       |                                 | 28a. Date of Injury (Month, Day, Year)<br><u>N/A</u>  |  | 28b. Time of Injury<br><u>N/A</u> M  |   | 28c. Injury at Work?<br><u>1</u> Yes <u>2</u> No                        |  |
| 29a. Certifier (Check only one)<br><u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                 |   | 29b. Signature and title of certifier<br><u>N. B. Vellanki</u> |  | 29c. License number<br><u>D. 30469</u>                      |   | 29d. Date signed (Month, Day, Year)<br><u>APRIL 23, 1997</u>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>N. B. VELLANKI, 9055 CHEVROLET DRIVE # 100, GAITHERSBURG CITY MD. 21042.</u>  |  |                                 |   |  |  |   |   |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><u>APR 28 1997</u>  |                                 |   |  | 32. Registrar's Signature<br><u>John Davidson-Randall</u>  |   |   |  |

Baltimore, Maryland 21245-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a-f show any injury or other traumatic event, a Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12557

## Certificate of Death

Reg. No.

|   |  |   |  |  |   |   |  |  |
|---|--|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DAVID GOLDMAN</b>                                 |   |  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>24</b> Year <b>1997</b> |   | 3. Time of Death<br><b>2025</b>                              |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SUBACUTE UNIT NORTHWEST</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>           |   | 4c. County of Death<br><b>BALTIMORE</b>                      |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-10-9720</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.                      |   | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 26, 1925</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                      |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>                                       |   | 10c. City, Town or Location<br><b>RANDALLSTOWN</b>           |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>8816 SIGRID RD.</b>  |  | 10f. Zip Code<br><b>21133</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>REPAIRMAN</b>                     |  | 16b. Kind of Business/Industry<br><b>TV/ELECTRONICS</b>  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ABRAHAM GOLDMAN</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>REBECCA OSOFSKY</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JUDY KENNEY (DAUG.)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3832 TERKA CIRCLE RANDALLSTOWN, MD 21133</b>   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OHEB SHALOM MEM. PARK</b>  |  | 20c. Date<br><b>4/27/97</b>  |   | 20d. Location - City or Town, State<br><b>REISTERSTOWN, MD</b>                                  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Ellen Sue Levinson</b>  |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>  |   |   |  |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>VENTRICULAR ARRHYTHMIA</b>  |  |   |  |  |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>E. Nami MD</b>  |  |   |  | 29c. License number<br><b>D37333</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 24, 1997</b>                                    |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>C. NAMI MD, NHC, BALTIMORE MD 21133</b>  |  |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  |   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or "accident," or "suicide," or "homicide," or "pending investigation," the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12558

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEOLA Goodman

2. Date of Death

April 25, 1997

3. Time of Death

22:30 pm

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

n/a

5. Social Security Number

426-24-0232

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 7, 1920

9. Birthplace (State or Foreign Country)

Miss.

Usual Residence of Decedent

10e. State

md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2119 W. Saratoga St.

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Diner

17. Father's Name (First, Middle, Last)

ROBERT BERRY

18. Mother's Name (First, Middle, Maiden Surname)

Kusy Owens

19a. Informant's Name/Relationship (Type, Print)

Betty A. Hall - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2225 Penrose Ave. Balto. md. 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Little Union Baptist Ch. Cem 5-1-97 Amelia, Va

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Thymus B. Starnin

22. Name and Address of Facility

March Funeral Home-West  
4300 Wabash Ave. Balto. md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal Failure

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Cardiomyopathy

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Aleksandr Povzhitkov

29c. License number

89286

29d. Date signed (Month, Day, Year)

04/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aleksandr Povzhitkov, M.D. c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0920

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If the death is due to natural causes, or items 23a or 28a-f show any injury or other traumatic cause, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12559

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty C. Gallagher

2. Date of Death

Month Day Year  
APRIL 24 97

3. Time of Death

3:10AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

220-18-3671

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 12, 1925

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State  
MARYLAND

10b. County

10c. City, Town or Location  
BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3407 ROSALIE AVE.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS.

College (1-4 or 5+)

4 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

CITY OF BALTIMORE

17. Father's Name (First, Middle, Last)

THOMAS COLLISON

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY SCHLEY

19a. Informant's Name/Relationship (Type, Print)

JAMES P. GALLAGHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3407 ROSALIE AVE. BALTIMORE, MARYLAND 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New CATHEDRAL

Date

APRIL 28 1997

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS CHAPEL OF MEMORIES  
8800 HARFORD ROAD - PARKVILLE

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 hours

b.

Aspergillus Pneumonia

Due to (or as a consequence of):

10 days

c.

Myelodysplastic Syndrome

Due to (or as a consequence of):

9 months

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Renal Failure

Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

April 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle Roberts 201 E. University Parkway, Baltimore, Md. 21218

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

[Signature]

State  
RegistrarBaltimore, Maryland 21215-0090  
permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural" or "Accident" or "Suicide" or "Homicide" or "Pending Investigation" or "Could not be determined", the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

(HW)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12560

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Joseph Hartman, Jr.

2. Date of Death

Month Day Year  
April 24 1997

3. Time of Death

1:15 P.M.

4a. Facility Name (If not institution, give street and number)

217 Chantrey Road

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

213-03-0583

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 10 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

217 Chantrey Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: '41-'45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

n/a

16e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Inspector

16b. Kind of Business/Industry

Western Electric

17. Father's Name (First, Middle, Last)

Edward J. Hartman, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Burr

19a. Informant's Name/Relationship (Type, Print)

Edward J. Hartman, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Piney Run Road, Medford, NJ 08055

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Victor Lengrand Jr.  
Victor Lengrand, Jr.

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE INSULIN DEPENDENT DIABETIC NEPHROPATHY years  
Due to (or as a consequence of): on dialysis (1.5.96)

b. INFILTRATING ADENOCARCINOMA OF ESOPHAGOGASTRIC JUNCTION-year  
Due to (or as a consequence of):

c. ISCHEMIC CONGESTIVE CARDIOMYOPATHY  
Due to (or as a consequence of):

d. CHRONIC ATRIAL FIBRILLATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY BYPASS GRAFT.

HYPOTHYROIDISM

INSULIN DEPENDENT NEUROPATHY.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lilia Ceballos, M.D.

29c. License number

D 25886

29d. Date signed (Month, Day, Year)

April-25-1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Lilia Ceballos, M.D.

Suite 501  
7505 Osler Dr., Towson, MD 21204

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature  
Julia Davidson-Rendell

State Registrar

Baltimore, Maryland 21215-0020

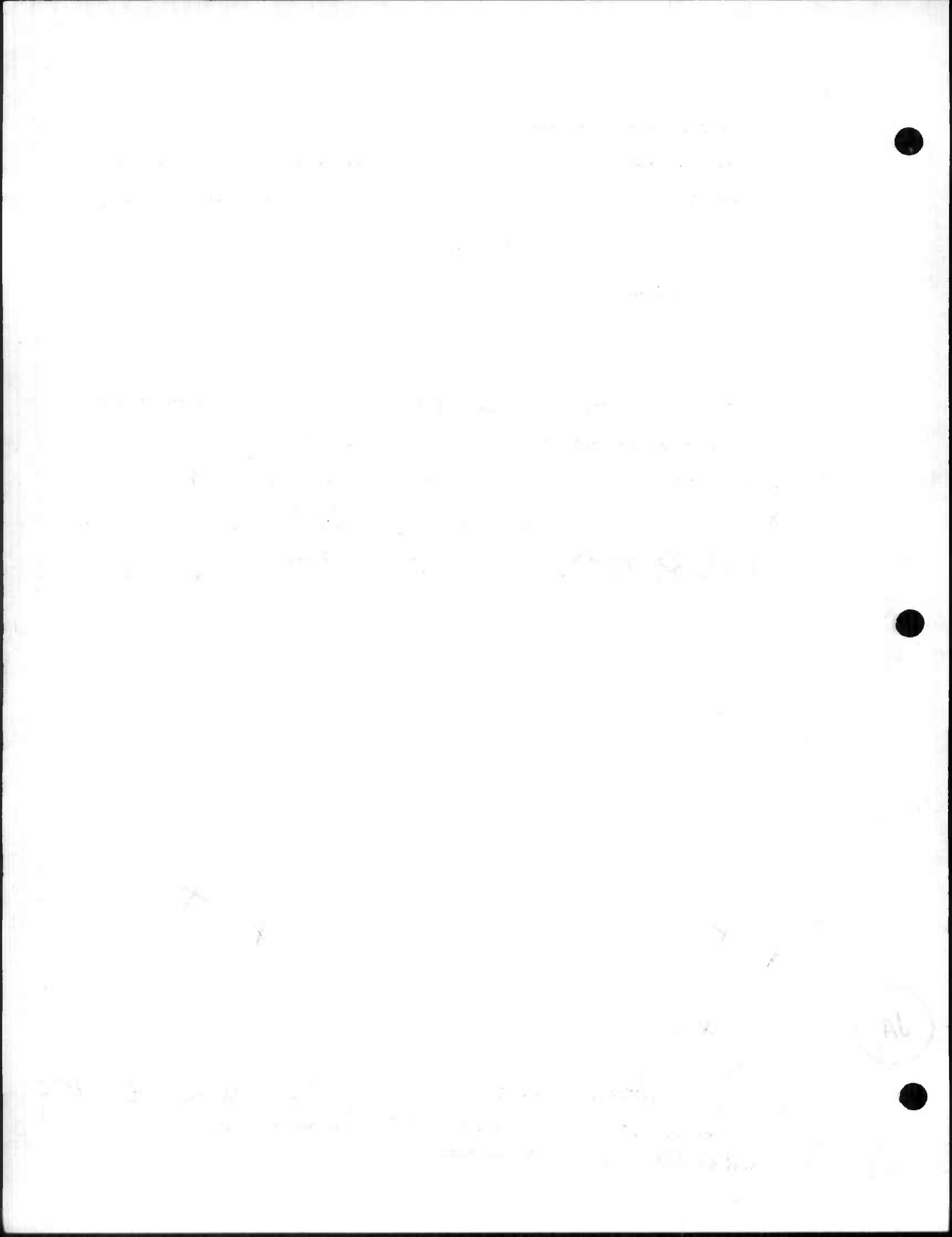
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed with 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

G+UA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12561

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Mary Dorothy Herbert   |  |   |  | 2. Date of Death<br>Month Day Year<br>April 22 1997   |  | 3. Time of Death<br>5:45 p.m.  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Stella Maris   |  |   |  | 4b. City, Town, or Location of Death<br>Towson  |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director   | 5. Social Security Number<br>216-09-9685   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>80 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>March 23, 1917                                |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>Maryland  |  | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Towson  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>2300 Dulaney Valley Road  |  | 10f. Zip Code<br>21204  |  | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+) n/a   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Health Care Technician                   |  | 16b. Kind of Business/Industry<br>Child Care  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>John Michael Glenn  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Madalena Kreager   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Timothy P. Herbert/Son   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2516 Rocks Road, Forest Hill, MD 21050   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sacred Heart of Jesus   |  | 20c. Location - City or Town, State<br>Dundalk, Maryland  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Bryan W. Clary  |  | 22. Name and Address of Facility<br>Lemmon Funeral Home<br>10 W. Padonia Road, Timonium, MD 21093   |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediata Cause (Final disease or condition resulting in death)<br>a. Cerebrovascular Accident<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |   |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| State Registrar   | 29b. Signature and title of certifier<br>J. Davidson-Randall   |  |   |  | 29c. License number<br>D 15504  |  | 29d. Date signed (Month, Day, Year)<br>April 23, 1997                                |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Eddie Nakhuda, M.D. 2300 Dulaney Valley Road, Towson, MD 21204   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 28 1997  |  |  |   | 32. Registrar's Signature<br>J. Davidson-Randall |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12562

Reg. No.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>THEODORE</b>  |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>23</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>8:45 PM.</b>  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b>  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-90-4297</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F      | 7. Age (In yrs. last birthday)<br><b>20</b> Yrs.  | If Under 1 Year<br>Months Days                               | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>04-14-77</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>  |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b>   |
|  | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
|  | 10e. Street and Number<br><b>235 North Milton Avenue</b>   |   | 10f. Zip Code<br><b>21224</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4 or 5+) <b>Na</b>  |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Prep Cook</b>  |   | 16b. Kind of Business/Industry<br><b>Restaurant</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Theodore A. Helm, Sr.</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lisa Stokes</b>   |  |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Lisa Stokes</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21224</b><br><b>235 N. Milton Avenue Baltimore, Maryland</b>   |  |  |
|  | 20e. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Cem. 04-26-97</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>   |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C. March FH 1101 E. North Avenue</b>  |  |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Gunshot Wounds</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  | 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)<br><b>4-23-97</b>   | 28b. Time of injury<br><b>2013 PM</b>                        | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>street</b>  |  | 28d. Describe how injury occurred<br><b>subject shot</b>                        |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Baltimore, Md</b><br><b>2400 E. Jefferson St</b>  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i><br><b>Dennis J. Chute MD</b>   |  | 29c. License number<br><b>O.C.M.E.</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 24, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dennis J. Chute MD</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i><br><b>Juba Davidson-Randall</b> |   |  |  |

Baltimore, Maryland 21215-0020  
perm. 1. Pages 1 and 2 should be filed within 72 hours after death in the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or "accident," or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12563

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BERTHA

JANKOWIAK

2. Date of Death

Month

Day

Year

APRIL

24

1997

3. Time of Death

9:45 PM

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

214-03-2561

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 18, 1907

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2902 Dunran Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 Years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Stanley Urbaniak

18. Mother's Name (First, Middle, Maiden Surname)

Pelagia Prus

19a. Informant's Name/Relationship (Type, Print)

Michael P. Jankowiak/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3811 Hebron Terrace Abingdon, Maryland 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Stanislaus Cemetery

Date

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

ASPIRATION PNEUMONIA

2 DAYS

Due to (or as a consequence of):

b.

THROMBOEMBOLUS RIGHT POPLITEAL A.

2 DAYS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

APRIL 24, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANDREW NOWAKOWSKI MD 125 N. MAIN ST. BEL AIR, MD 21014

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours of death with the Maryland  
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 27 is marked "natural" and item 28 is marked "not natural", the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



97 12564

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |  |
|---|--|--|--|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Hattie Johnson</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>4</i> DAY <i>22</i> YEAR <i>97</i>   |  | 3. TIME OF DEATH<br><i>9am</i> M  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>229 26 3838</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>83</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>2-13-14</i>                |   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><i>Harford Gardens Dsg. Center</i>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore, Maryland</i>   |  | 8c. COUNTY OF DEATH<br><i>NA</i>  |   |  |
| 10a. STATE<br><i>MD.</i>  |  |  |  | 10b. COUNTY<br><i>NA</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>                         |   |  |
| 10e. STREET AND NUMBER<br><i>919 Valley Street</i>  |  |  |  | 10f. ZIP CODE<br><i>21201</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                             |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i> |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>6th Grade</i><br>College (1-4 or 5+) <i>NA</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working<br>life. Do NOT use retired.)<br><i>Domestic</i>          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>various trades</i>   |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Ed Deloatch</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Classie Williams</i>  |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Teresa Davis</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>702 East 20th Street Baltimore, Md. 21218</i>   |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of<br>cemetery, crematory or other place)<br><i>King Memorial Pk Cem. 04-26-97</i>                  |  | 20c. LOCATION — City or Town, State<br><i>MD. Randallstown,</i>   |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Baltimore, Md. 21202<br/>WM.C. March FH 1101 E. North Avenue</i>   |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive heart failure</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>b. <i>Cardiomyopathy</i></p> <p>c. <i>Atrial fibrillation</i></p> <p>d. <i>Anaemia</i></p> </div> <div style="width: 30%;"> <p>a. <i>Due to (or as a consequence of):</i></p> <p>b. <i>Due to (or as a consequence of):</i></p> <p>c. <i>Due to (or as a consequence of):</i></p> <p>d. <i>Due to (or as a consequence of):</i></p> </div> </div> |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Prerenal insufficiency</i><br><i>Dementia</i>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |   | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  |
| 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE NOW INJURY OCCURRED                                       |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature] MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D 31464</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>4/22/97</i>                   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>SHOAB A. HASHTMI MD, 821 N. Eutaw St Suite 308 Balt. MD 21201</i>   |  |  |  |   |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 28 1997</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12565

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JANIS JOHNSON

2. Date of Death

Month

Day

Year

APRIL

25

97

3. Time of Death

1:00 AM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Baltimore City

5. Social Security Number

219-16-5159

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

Jan. 21, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

608 Park Road

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Ezra Oscar

Holbrook

18. Mother's Name (First, Middle, Maiden Surname)

Roberta M. Gibson

19a. Informant's Name/Relationship (Type, Print)

Byron Johnson ( Son )

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

608 Park Road Severna Park, MD. 21146

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Date

4/26/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCurry Funeral Home of Brooklyn

237 E. Patapsco Ave. Balto., MD. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Approximate Interval Between Onset and Death

5-6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE LUNG DISEASE

3-4 YEARS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTHROSCLECTIC CARDIOVASCULAR DISEASE

UNSTABLE ANGINA

ATRIAL FIBRILLATION PAROXYSMAL

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marushko Bindra EXTERM

29c. License number

AS2441614-25

29d. Date signed (Month, Day, Year)

APRIL 25 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARUSHKA BINDRA HARBOR HOSPITAL CENTER DEPARTMENT OF MEDICINE

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

J. H. Anderson-Randall

State Registrar

Baltimore, Maryland 21215-0030  
permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than natural, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

179

146

Mar. 6

S



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12566

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARJAN KOL OBIELSKI

2. Date of Death

Month Day Year  
APRIL 24 1997

3. Time of Death

9<sup>30</sup> P.M.

4a. Facility Name (If not institution, give street and number)

Gilchrist Hospice Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

094 30 7263

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 17, 1915

9. Birthplace (State or Foreign Country)

Poland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6710 Sherwood Rd.

10f. Zip Code

21239

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Research Chemist

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Max

Kolobielski

18. Mother's Name (First, Middle, Maiden Surname)

Pearl

(Unknown)

19a. Informant's Name/Relationship (Type, Print)

Joan Kolobielski, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6710 Sherwood Rd., Baltimore, MD 21239

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 4/26/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licentiate

*Stephen D. Lohrmann*

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.  
8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive HEART FAILURE

Due to (or as a consequence of):

b. ISCHEMIC HEART DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

12 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*James H. Gordon, MD*

29c. License number

D 15561

29d. Date signed (Month, Day, Year)

4/25/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James B. Addison, MD 7401 Osler Dr, Balto, MD 21204

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

*John Davidson-Randall*

State  
Registrar

Baltimore, Maryland 21215-0001  
permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

HW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12567

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William F. Kehn</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>27</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>9:45 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1308 Elrino Way</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>n/a</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214 14 3108</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 29, 1911</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>n/a</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| To Be Completed by<br>Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1308 Elrino Way</b>  |  | 10f. Zip Code<br><b>21224</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by<br>Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Painter</b>                       |  | 16b. Kind of Business/Industry<br><b>Construction Interior</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Glenroy Kehn</b>   |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bertha (Unknown)</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph F. Kehn / son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1308 Elrino Way, Baltimore, MD 21224</b>   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |
| To Be Completed by<br>Physician/Medical Examiner   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>CAFA Stephen D. Lohrmann P.A.<br/>8717 Green Pastures Dr., Baltimore, MD 21286</b>  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Dementia</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>years</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by<br>Physician/Medical Examiner   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |
|  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
| To Be Completed by<br>Physician/Medical Examiner   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Cynthia Kuttner - Sands, MD</b>  |  |
|  | 29c. License number<br><b>D47451</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/25/97</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Cynthia Kuttner - Sands, MD Johns Hopkins Geriatric Center, Baltimore, Maryland 21224</b>   |  | 31. Data filed (Month, Day, Year)<br><b>APR 28 1997</b>  |  |
| 32. Registrar's Signature<br> |   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or "Binge" or "28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12568

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ADA KERXTON

2. Date of Death

Month Day Year  
APRIL 19 1997

3. Time of Death

5:05 AM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

216-56-8080

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
JULY 10, 1902

9. Birthplace (State or Foreign)

MARYLAND

Usual Residence of Decedent

10a. State  
MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7920 SCOTTS LEVEL ROAD

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SOLOMON

ENGEL

18. Mother's Name (First, Middle, Maiden Surname)

JESSIE

ROSENSTEIN

19a. Informant's Name/Relationship (Type, Print)

ARTHUR DRAGER (ATTY.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 LIGHT ST., SUITE 510 BALTIMORE, MD 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ANSHE EMUNAH(AITZ CHAIM) 4-24-97

Date

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Scott M. Cutler

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

b. MALNUTRITION

Due to (or as a consequence of):

c. CACHEXIA

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

4 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

MD

29c. License number

BG 4439128

29d. Date signed (Month, Day, Year)

APRIL 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS GEORGE, NORTHWEST  
HOSPITAL CENTER, 5401 OLD COURT ROAD, RANDALLSTOWN 21133.

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or "accident," or "suicide," or "homicide,"  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 12569

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KHAVA KAGANOVICH</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 25 1997</b>  |  | 3. TIME OF DEATH<br><b>8:30 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-43-9375</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JAN. 8, 1909</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2922 TANEY RD., APT. 2-C</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH<br><b>N/A</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>N/A</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO        |  |
| 10e. STREET AND NUMBER<br><b>2922 TANEY RD., APT. 2-C</b>  |  |  |  | 10f. ZIP CODE<br><b>21209</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>BELARUS</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LAZAR GEHMAN</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>GETA GEHMAN</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>NISEL KAGANOVICH (SON)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2922 TANEY RD., APT. 2-C BALTO., MD 21209</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARLINGTON (CHIZUK AMUNO)</b>   |  | DATE<br><b>4/27/97</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO., MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jayne Feldman</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>COLON CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CORONARY ARTERY DISEASE</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jaeween Jalehan</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>12895</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/25/97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TASNEEM CAKHTANI, 2220 PARK HEIGHTS AVE BALTO MD 21202</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 28 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Pandella</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
BALTIMORE, MARYLAND 21215-0080

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or funeral home for their records. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12570

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>WILMA L. KLIPA</b>  |  |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>25</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>11:56 AM</b>                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Northwest Hospital Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Randallstown</b>   |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217-36-4604</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 30, 1941</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Balto. Md.</b>  |  | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Reisterstown</b>                      |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>4 Chardon Court</b>  |  | 10f. Zip Code<br><b>21136</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 Yrs. College</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner</b>   |  | 16b. Kind of Business/Industry<br><b>Day Care Center</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Maurice Falck</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sylvia Freedman</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>James C. Klipa (Husband)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4 Chardon Court Reisterstown, Md. 21136</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation Service</b>  |  | 20c. Location - City or Town, State<br><b>4/29/97 Hampstead, Md.</b>  |  | 21. Signature of Funeral Service Licensee<br><i>Frank B. Eline</i>      |  |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility<br><b>ELINE FUNERAL HOME Reisterstown, Md. 21136</b>  |  |   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPTICEMIA</b><br>Due to (or as a consequence of):<br><b>RENAL FAILURE</b><br>Due to (or as a consequence of):<br><b>CELLULITIS LEG</b><br>Due to (or as a consequence of):<br><b>PNEUMONIA</b> |  |   |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PNEUMOTHORAX.</b>  |  |   |  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br><i>Dr. H. J. Fil</i> MD  |  | 29c. License number<br><b>D 27157</b>                                   |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>APRIL 25, 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RAYNOLD DEPESTRE NORTHWEST HOSPITAL CENTER</b>   |  | 31. Data filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  |   |  |
|   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |  |   |  | 33. Registrar's Title<br><b>State Registrar</b>   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

5



97 12571

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Florence J. Kinson   |  |  |  | 2. DATE OF DEATH<br>MONTH April 13, 1997 DAY YEAR   |  | 3. TIME OF DEATH<br>0800 M   |  |
| 4. SOCIAL SECURITY NUMBER<br>019-10-5444   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>80 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>April 2, 1917  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>New Hampshire  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Laurel Wood Nursing Center  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Elton   |  |
| 9c. COUNTY OF DEATH<br>Cecil   |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Montgomery  |  |
| 10c. CITY, TOWN OR LOCATION<br>Georgetown  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>P.O. Box 300   |  |
| 10f. ZIP CODE<br>21930   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES unknown  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) unknown College (1-4 or 5+) unknown  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>bookkeeper   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>unknown   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>unknown   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>unknown  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Joanne Farus/daughter  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 300, Georgetown, Maryland 21930   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in-state   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>DATE   |  |  |  |
| 20c. LOCATION — City or Town, State  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Joseph B. Van Sant   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>State Anatomy Board, 655 W. Baltimore St.<br>Baltimore, Maryland 21201   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Adenocarcinoma of Unknown Primary<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate interval Between Onset and Death 2 MONTHS<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY M<br>28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURED<br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Monte Makous, MD<br>29c. LICENSE NUMBER<br>D-44783<br>29d. DATE SIGNED (Month, Day, Year)<br>APRIL 15, 1997  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MONTE MAKOUS, MD 111 WEST HIGH STREET, ELKTON, MD 21921   |  |  |  | 31. DATE FILED (Month, Day, Year)<br>APR 25 1997  |  |  |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12572

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT CONRAD

KAIFER, S.R.

2. Date of Death

Month

Day

Year

APRIL

25

1997

3. Time of Death

0435

AM

4a. Facility Name (If not institution, give street and number)

GILCHRIST CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-05-6780

6. Sex

M ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

OCT-23, 1907

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2607 TAYLOR AVE.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10YRS.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MECHANIC

16b. Kind of Business/Industry

GAS STATION

17. Father's Name (First, Middle, Last)

JOSEPH M. KAIFER

18. Mother's Name (First, Middle, Maiden Surname)

MARY A. HALL

19a. Informant's Name/Relationship (Type, Print)

MARGARET M. KAIFER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2607 TAYLOR AVE. PARKVILLE, MARYLAND 21234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

APRIL 29 1997

20c. Location - City or Town, State

PARKVILLE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVAN CHAPEL OF MEMORIES  
8800 HARFORD ROAD - PARKVILLE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. GLIOBLASTOMA MULTIFORME

Due to (or as a consequence of):

b. Right upper lobe Pulmonary abscess

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr.

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☒ Other (Specify)

Inpt hospice

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D47707

29d. Date signed (Month, Day, Year)

April 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RITA PABLA MD 6565 N. Charles St Ste 203 Baltimore MD 21204

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

[Signature]

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours of death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", a "natural" death must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

(HW)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12573

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Land

2. Date of Death

April 23 97

3. Time of Death

3:00pm

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

212-16-5933

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

07-04-1900

9. Birthplace (State or Foreign Country)

SC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

731 E. 21st. Street

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Home-maker

16b. Kind of Business/Industry

in home

17. Father's Name (First, Middle, Last)

William A. McCrorey

18. Mother's Name (First, Middle, Maiden Surname)

Mary Hoffman

19a. Informant's Name/Relationship (Type, Print)

James Land

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21218  
731 East 21st. Street Baltimore, Maryland

20a. Method of Disposition

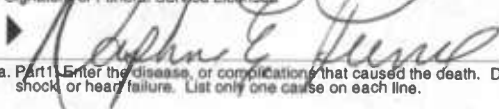
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Baltimore Cemetery 04-28-97 Baltimore, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Baltimore, Maryland  
WM.C.March FH 1101 E. North Avenue23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Cardio pulmonary arrest

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

15 minutes

b.

Arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

years

c.

Hypertension

Due to (or as a consequence of):

&gt;6 years

d.

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Decubitus ulcers

Dementia

Malnutrition

h/o intracranial bleed

Fractured hip 4/6/97

5191

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D30717

29d. Date signed (Month, Day, Year)

April 23 1997

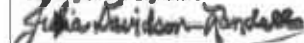
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alicia A Cool MD 200 E 33rd St Suite 205 Baltimore MD 21218

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0000  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12574

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Georgia Laws

2. Date of Death

Month Day Year  
April 26 1997

3. Time of Death

3:30 PM

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-16-0044

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 24, 1916

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2735 Round Rd.

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

House keeper

18b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

George Holmes

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Newsome

19a. Informant's Name/Relationship (Type, Print)

Lawson Laws/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2735 Round Rd. Baltimore, MD 21225

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forest

Date

5/1

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

James A. Morton & Sons Funeral Home  
1701 Laurens St. Balto., MD 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Staphylococcal Septicemia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 days

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Wro sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Resident Physician  
James A. Morton

29c. License number

AS 2441614-41

29d. Date signed (Month, Day, Year)

April 26 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SYED N ZAFAR, HARBOR HOSPITAL CENTER

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death. The Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or "trauma," or "accident," or "injury" or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12575

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Marie McInnes

2. Date of Death

Month Day Year  
April 22, 1997

3. Time of Death

8:10 am

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

218 68 1397

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 10, 1910

9. Birthplace (State or Foreign Country)

BALTIMORE

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Rd.

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John William Pontier

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Kratzer

19a. Informant's Name/Relationship (Type, Print)

Donald A. McInnes, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13700 Bardon Rd., Phoenix, MD 21131

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Carroll Cremation Services 1997

Date

25 APR

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensed

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.  
10 W. Padonia Rd., Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Dementia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D2568C

29d. Date signed (Month, Day, Year)

4-22-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ebrahim Ipakchi, M.D.

2300 Dulaney Valley Rd

Towson, Md. 21204

31. Date filed (Month, Day, Year)

APR 28 1997

32. Signature of Registrar

John Anderson-Rendella

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

This Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12576

Reg. No.

|   |   |  |   |   |  |  |  |  |
|---|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>ABRAM H MITCHELL  |  |   |   | 2. Date of Death<br>Month Day Year<br>APRIL 25 1997  |  | 3. Time of Death<br>10:55 AM                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>St Agnes  |  |   |   | 4b. City, Town, or Location of Death<br>Baltimore  |  | 4c. County of Death<br>NA  |  |
| Funeral<br>Director   | 5. Social Security Number<br>237-28-5281  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>81 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>APRIL 27, 1915            |  |
|   | 9. Birthplace (State or Foreign Country)<br>N.C.  |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  | 10a. State<br>MD  |   | 10b. County<br>N/A   |  | 10c. City, Town or Location<br>Baltimore                         |  |
|   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>2873 Riggs Ave.   |   | 10f. Zip Code<br>21216   |  | 10g. Citizen of What Country?<br>USA                             |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: 1941-1946 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>auto mechanic                                      |   | 16b. Kind of Business/Industry<br>auto repair  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>ABRAM H. MITCHELL  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>ADA TAYLOR  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>ABRAM O. MITCHELL / son   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4720 YORK ROAD BALTIMORE, MD 21212  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MITCHELL Cemetery   |   | 20c. Location - City or Town, State<br>FORT BARNESWELL, NC.  |  | Date<br>5/4/91   |  |
|   | 21. Signature of Funeral Service Licensee   |  |   |   | 22. Name and Address of Facility<br>ALBERT P. WYLLIE F/H PA<br>638 N. GILMOR ST. BALTIMORE, MD 21217   |  |  |  |
|   | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |  |   |   |  |  |  |  |
|   | Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br>a. Atherosclerotic coronary vessel disease 10 years<br>Due to (or as a consequence of):<br>b. Hypertension 10 years<br>Due to (or as a consequence of):<br>c. hyperkalemia 2 days<br>Due to (or as a consequence of):<br>d.       |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Dehydration   |   |  |   |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |   |   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>Physician  |   |  |   | 29c. License number<br>DS0708   |  | 29d. Date signed (Month, Day, Year)<br>April 25 <sup>th</sup> , 1997                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>900 South Euter Avenue Baltimore  |   |  |   |   |  |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>APR 28 1997  |  |   |   | 32. Registrar's Signature<br>Julia Davidson-Randall  |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", pages 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 12577

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES

MCNULTY

2. Date of Death

Month  
APRILDay  
26Year  
1997

3. Time of Death

1:30 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

212-07-0481

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
02/14/1915

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

401 Lake Vista Circle, Apt. H

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Purchasing

16b. Kind of Business/Industry

McCormick Spice Co.

17. Father's Name (First, Middle, Last)

Frank McNulty

18. Mother's Name (First, Middle, Maiden Summa)

Marie Cecelia McCloskey

19a. Informant's Name/Relationship (Type, Print)

Emily McCloskey (Aunt)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401 Lake Vista Circle, Apt. H, Cockeysville, MD 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

4/28/97

20c. Location - City or Town, State

Baltimore, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd., Towson, MD. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure.

Due to (or as a consequence of):

b. Severe COPD + Pulmonary Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

Renal failure and Arteriosclerosis of Heart

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide 6 ☐ Could not be determined4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

220764

29d. Date signed (Month, Day, Year)

4/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6801 Belair Road Baltimore MD 21206

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12578

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
|--|---|---|--|--|--|--|--|---|----|--------------------------|---|----------------------------------|--|--|----|-------------------------------|--------------|----------------------------------|--|--|----|--|--|--------------|----------------------------------|--|--|----|---------------------|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HENDERSON MULDROW, SR</b>                |   |  |  | 2. Date of Death<br>Month <b>04</b> Day <b>23</b> Year <b>97</b> |  | 3. Time of Death<br><b>1250P</b>                           |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>         |  | 4c. County of Death<br><b>Baltimore</b>                    |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>247-46-7128</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.                 |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT 31, 1930</b> |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
|  | Usual Residence of Decedent   |   | 10a. State<br><b>Md</b>  |  | 10b. County<br><b>NA</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>            |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>4107 Boarman Avenue</b>  |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A</b>                                    |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>          |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2nd</b> College (1-4 or 5+) <b>NA</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction Contractors</b>  |  | 16b. Kind of Business/Industry<br><b>Construction Co.</b>  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Albert Muldrow</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Muldrow</b>  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dianne Muldrow-Daughter</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>506 W. Hanover Ave Trenton, N.J 08618</b>  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Mem Park</b>  |  | 20c. Location - City or Town, State<br><b>428-97 Randallstown, Md</b>  |  | 20d. Date<br><b>21215</b>  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 21. Signature of Funeral Service Licensee<br><b>John B. Johnson</b>  |   |   |  | 22. Name and Address of Facility<br><b>March 5th West 4500 Unbash Avenue Baltimore 21215</b>   |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Pulmonary Embolus</b></td> <td>Approximate Interval Between Onset and Death<br/><b>12 hrs</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>MYO CARDIAL INFARCTION</b></td> <td><b>6 hrs</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="2"><b>Chronic obstructive pulmonary disease</b></td> <td><b>years</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="2"><b>Hypertension</b></td> <td></td> </tr> </table> |   |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Pulmonary Embolus</b> | Approximate Interval Between Onset and Death<br><b>12 hrs</b> | Due to (or as a consequence of): |  |  | b. | <b>MYO CARDIAL INFARCTION</b> | <b>6 hrs</b> | Due to (or as a consequence of): |  |  | c. | <b>Chronic obstructive pulmonary disease</b> |  | <b>years</b> | Due to (or as a consequence of): |  |  | d. | <b>Hypertension</b> |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.  | <b>Pulmonary Embolus</b>  | Approximate Interval Between Onset and Death<br><b>12 hrs</b>              |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
|  | Due to (or as a consequence of):  |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
|  | b.  | <b>MYO CARDIAL INFARCTION</b>   | <b>6 hrs</b>   |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
|  | Due to (or as a consequence of):  |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| c.   | <b>Chronic obstructive pulmonary disease</b>  |   | <b>years</b>   |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| Due to (or as a consequence of):   |   |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| d.   | <b>Hypertension</b>   |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 29b. Signature and title of certifier<br><b>J. M. Poitras MD</b>   |   |   |  | 29c. License number<br><b>D46949</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 23, 1997</b>                     |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>J. M. Poitras MD, Sinai Hospital, Balt. MD</b>  |   |   |  |  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |   |   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>  |  |  |  |   |    |                          |   |                                  |  |  |    |                               |              |                                  |  |  |    |  |  |              |                                  |  |  |    |                     |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," item 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

UIC



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12579

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |   |  |  |
|---|---|--|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>DELBERT B. MONTAQUE</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 22 1997</b>  |  | 3. Time of Death<br><b>6:25 PM</b>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>500 BLK. LAURENS STREET</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>n/a</b>   |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217-11-3318</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>24</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JUL 21, 1972</b>  |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>BALTIMORE, MD</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>2619 QUANTICO AVENUE</b>   |  | 10f. Zip Code<br><b>21215</b>   |  |  |
|   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>   |  |  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12<sup>th</sup></b> College (14 or 5+) <b>-</b> |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>BALTIMORESUN NEWSPAPER</b>   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>GLEN MONTAQUE SR.</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CLARA JEAN SHERROD</b>  |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>GLEN MONTAQUE</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2619 QUANTICO AVENUE, BALTIMORE, MD 21215</b>   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>   |  | 20c. Location - City or Town, State<br><b>4-28-97 RANDALLSTOWN, MD</b>  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>James A. Thompson</i>   |  |  |  | 22. Name and Address of Facility<br><b>WM.C.MARCHFH-WEST- 4300 WABASH AVE, BALTO, MD</b>  |  |   |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. <i>Gunshot Wound of Head</i></b><br>Due to (or as a consequence of):<br><br><b>b. <i>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</i></b><br>Due to (or as a consequence of):<br><br><b>c. <i>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</i></b><br>Due to (or as a consequence of):<br><br><b>d. <i>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</i></b><br>Due to (or as a consequence of): |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SIDEWALK</b> |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day Year)<br><b>4/22/97</b>   |  | 28b. Time of Injury<br><b>1816HR M</b>  |  |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 28d. Describe how injury occurred<br><b><i>Subject shot</i></b>   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b><i>sidewalk</i></b>  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b><i>500 block Laurens Street Baltimore, Maryland</i></b>  |  |   |  |  |
|   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. Signature and title of certifier<br><b><i>Theodore M. King</i></b>   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>O.C.M.E.</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 23, 1997</b>  |  |   |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b><i>THEODORE M. KING</i></b><br><b>111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  |   |  |  |
| State Registrar                               | 32. Registrar's Signature<br><b><i>John Davidson-Randall</i></b>  |  |  |  | 33. Date of Death (Month, Day, Year)<br><b>APR 22 1997</b>  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12580

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Catherine MUNDY</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>April 25, 1997</b>   |  | 3. Time of Death<br><b>6:07 am</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-44-1046</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 12, 1912</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Chase</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>12626 Eastern Avenue Ext.</b>  |  | 10f. Zip Code<br><b>21027</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)                           |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>George Rose</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Melodie Jones</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>David Mundy (son)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1205 Tupelo Place Baltimore, Md. 21220</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ebenezer Meth.Ch. Cemetery</b>   |  |   |  |
|   | 20c. Location - City or Town, State<br><b>Baltimore, Co.</b>   |  |  |  | 20d. Date<br><b>4/28/1997</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Bruzdzinski Funeral Home P.A.<br/>1407 Old Eastern Avenue Essex, Md 21221</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>b. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>1 Hour</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |
|   | 28a. Date of Injury (Month, Day Year)<br><b>April 25, 1997</b>   |  |  |  | 28b. Time of Injury<br><b>M</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  | 28d. Describe how injury occurred   |  |   |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  | 29b. Signature and title of certifier<br>   |  |   |  |
|   | 29c. License number<br><b>D47765</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>April 25, 1997</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Selwyn Mahon M.D. 6603 Evanston Street, Forestville, Maryland 20747</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  |   |  |
|   | 32. Registrar's Signature<br>  |  |  |  | 33. Registrar's Name<br><b>J. Davidson-Randall</b>  |  |   |  |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12581

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Mueller

2. Date of Death

Month

Day

Year

3. Time of Death

4 12 97 6:35pm

4e. Facility Name (If not institution, give street and number)

Canton Harbor Health Care

4b. City, Town, or Location of Death

Baltimore, MD

4c. County of Death

Funeral  
Director

5. Social Security Number

215-01-3265

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2/18/19

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1300 South Elwood Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

Roy Hacker

18. Mother's Name (First, Middle, Maiden Surname)

Dora Ellen Fink

19e. Informant's Name/Relationship (Type, Print)

Stephanie Lyon/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8902 Stonebrook Lane, Columbia, Maryland 21046

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's - type dementia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robb Wilentz MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

4/13/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

600 N. Wolfe Street Baltimore, MD 21287

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12582

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IDA

MERRIAM

2. Date of Death

Month Day Year  
APRIL 8, 1997

3. Time of Death

4:35AM

4a. Facility Name (If not institution, give street and number)

Prince George County General Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George

Funeral  
Director

5. Social Security Number

577-60-2271

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 6, 1904

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Bowie

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10450 Lottsford Road

10f. Zip Code

20721

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Economist

16b. Kind of Business/Industry

Social Services

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 25079

29d. Date signed (Month, Day, Year)

4/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD YABLOKOWITZ, MD 7404 EXECUTIVE PL. #502 JETROCK, MD 20706

State  
Registrar

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Wilson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

WASH. D. C. 20540

OFFICE OF THE SECRETARY

NOV 1964

MEMO

TO: THE SECRETARY

FROM: [illegible]

SUBJECT: [illegible]

1

1. [illegible]

2. [illegible]

3.

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97 12583

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>HELEN R MATTHEWS</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>26</b> YEAR <b>97</b>  |  | 3. TIME OF DEATH<br><b>9:32p</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-74-8097</b>   |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-7-13</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>BAYVIEW MEDICAL CENTER</b>   |  | 10. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |
| 11. COUNTY OF DEATH<br><b>n/a</b>   |  |   |  | 12. STATE<br><b>Md.</b>  |  | 13. COUNTY<br><b>n/a</b>  |  |
| 14. STREET AND NUMBER<br><b>230 E. Cross Street</b>   |  |   |  | 15. ZIP CODE<br><b>21230</b>   |  | 16. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 17. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  |   |  | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  |
| 20. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |   |  | 21. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or S+) <b>0</b>   |  | 22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife/domestic</b>  |  |
| 23. KINO OF BUSINESS/INDUSTRY<br><b>Home Owner</b>  |  |   |  | 24. FATHER'S NAME (First, Middle, Last)<br><b>Charles Gauss</b>  |  | 25. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence Finkel</b>   |  |
| 26. INFORMANT'S NAME (Type and Print)<br><b>Helen Smith (Daughter)</b>  |  |   |  | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>305 E. Cross Street, Baltimore, Md. 21230</b>   |  |   |  |
| 28. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  |   |  | 29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glen Haven Mem. Park 4/30/97</b>  |  | 30. LOCATION — City or Town, State<br><b>Glen Burnie, Md.</b>   |  |
| 31. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Daniela Vayls</b>   |  |   |  | 32. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of South Balto.<br/>130 E. Fort Ave., Baltimore, Md. 21230</b>   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 24. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |   |  | 25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |   |  |
| 26. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |   |  | 27. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |
| 28. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  |   |  | 29. DATE OF INJURY (Month, Day, Year)  |  | 30. TIME OF INJURY<br><b>M</b>  |  |
| 31. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |   |  | 32. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 33. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 34. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 35. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |
| 36. SIGNATURE AND TITLE OF CERTIFIER<br><b>John Dugan</b>   |  |   |  | 37. LICENSE NUMBER<br><b>0-47282(DC)</b>   |  | 38. DATE SIGNED (Month, Day, Year)<br><b>4-27-97</b>  |  |
| 39. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SHARI LING, MD 5505 HOPKINS BAYVIEW CIRCLE</b>  |  |   |  |  |  |   |  |
| 40. DATE FILED (Month, Day, Year)<br><b>APR 28 1997</b>   |  |   |  | 41. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
 BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12584

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD

MCDANIEL

2. Date of Death  
Month Day Year

APRIL 23, 1997

3. Time of Death

6:54PM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

213-34-3774

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Month Day Year

April 11, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3031 Hamilton Ave.

10f. Zip Code

21214

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SERVICE TECHNICIAN

16b. Kind of Business/Industry

SEARS

17. Father's Name (First, Middle, Last)

Harry L. McDaniel

18. Mother's Name (First, Middle, Maiden Surname)

Doris Miller

19a. Informant's Name/Relationship (Type, Print)

Richard D. McDaniel, Jr. SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

427 Dunkirk Rd. Baltimore Maryland 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON Forest Cemetery

Date

April 28 1997

20c. Location - City or Town, State

GARRISON Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Evans Chapel of Memories  
8800 Harford Rd. Baltimore, Md. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Cancer

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D47083

29d. Date signed (Month, Day, Year)

4/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan M. Cassidy, RBMC Hospital, Baltimore, Md.

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12585

Reg. No.

|  |  |  |  |   |   |  |  |   |  |
|--|--|--|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD MILLER</b>                                    |  |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 25, 1997</b>     |  | 3. Time of Death<br><b>3:00 AM</b>                             |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SAINT JOSEPH MEDICAL CENTER</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>TOWSON, MARYLAND</b> |  | 4c. County of Death<br><b>BALTIMORE</b>                        |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217 20 5264</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.                |  | 8. Date of Birth (Month, Day, Year)<br><b>December 29 1926</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>                                 |  | 10c. City, Town or Location<br><b>Perry Hall</b>               |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3800 B. Wean Drive</b>   |   | 10f. Zip Code<br><b>21236</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:              |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>                                 |  | 16b. Kind of Business/Industry<br><b>C &amp; P Telephone</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Peter Preston Miller</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn Edith Tedford</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>EVA KAVANAGH sister</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7910 Aiken Ave. Parkville, Maryland 21234</b>              |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial Gardens</b>   |  | 20c. Location - City or Town, State<br><b>Timonium, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Curie K...</b>   |  | 22. Name and Address of Facility<br><b>EVANS Chapel of Memories<br/>8800 Hartford Rd. Baltimore, MD. 21234</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>RESPIRATORY FAILURE SECONDARY TO<br/>SMALL CELL CARCINOMA OF LUNG WITH<br/>METASTASIS</b> |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  | 23c. Approximate Interval Between Onset and Death<br><b>10 DAYS</b>   |  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Joginder P. Mehta M.D.</b>   |  | 29c. License number<br><b>D41410</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 25, 1997</b>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOGINDER P. MEHTA, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204</b> |  | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |   | 32. Registrar's Signature<br><b>Johia Davidson-Randall</b>   |  |   |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12586

Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |  |  |
|---|--|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Marie Kathleen Morissette  |  |   |  | 2. Date of Death<br>Month Day Year<br>April 24 1997   |  |  |  | 3. Time of Death<br>2:30AM   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>6816 Lenbern Road  |  |   |  | 4b. City, Town, or Location of Death<br>Baltimore   |  |  |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>218-35-8128   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>4 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>May 9, 1992                                   |  | 9. Birthplace (State or Foreign Country)<br>MD   |  |
|   | Usual Residence of Decedent  |  |   |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>MD   |  | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Baltimore  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>6816 Lenbern Road  |  |   |  | 10f. Zip Code<br>21207  |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0 College (1-4 or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Child |   |  | 16b. Kind of Business/Industry<br>Child  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Paul Leo Morissette   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Kathleen Hoots   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Paul Morissette (Father)   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6816 Lenbern Rd. Baltimore, MD 21207   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Woodlawn Cemetery   |  | 20c. Date<br>Apr. 28, 1997  |  | 20d. Location - City or Town, State<br>Woodlawn, MD                                  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Robert S. Buhner  |  |   |  | 22. Name and Address of Facility<br>Witzke Funeral Homes, Inc.<br>5555 Twin Knolls Rd. Columbia, MD 21045   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. cardiorespiratory failure<br>Due to (or as a consequence of):<br>b. neuroblastoma<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  |  |  |  |  |
| State Registrar                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br>Christopher N. Frawley MD  |  | 29c. License number<br>D39666  |  | 29d. Date signed (Month, Day, Year)<br>April 24 1997   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Christopher Frawley MD, Dept Pediatrics, Univ Maryland Baltimore MD 21201  |  |   |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>APR 28 1997   |  |   |  | 32. Registrar's Signature<br>John Davidson-Randall  |  |  |  |  |  |

Baltimore, Maryland 21245-0020  
permit. Pages 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural" for items 23a or 23b-f show any injury or other traumatic event. The Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

(HW)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Item23PartI 4-28-97 FilmG746 W.H.Per Doctor

## Certificate of Death

Reg. No.

97 12587

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bertha Mize

2. Date of Death

Month Day Year

4 21 97

3. Time of Death

1400

4a. Facility Name (If not institution, give street and number)

Umons

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

212-20-0065

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

8-3-14

9. Birthplace (State or Foreign Country)

Unknown

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

611 South Charles Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNK

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

UNK

16b. Kind of Business/Industry

UNK

17. Father's Name (First, Middle, Last)

UNK

18. Mother's Name (First, Middle, Maiden Surname)

UNK

19a. Informant's Name/Relationship (Type, Print)

Artie Shaw

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

861 Park Ave 3rd Floor Baltimore, MD 21201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MNT. ZION

Date

4-23-97 Landbourne, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Albert P. Wylic Funeral Home P.A.  
638 N. Gilman Baltimore, Maryland 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Acute Myocardial Infarction

Sudden Cardiac Death

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician 2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D37818

29d. Date signed (Month, Day, Year)

4/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Umons

State Registrar

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

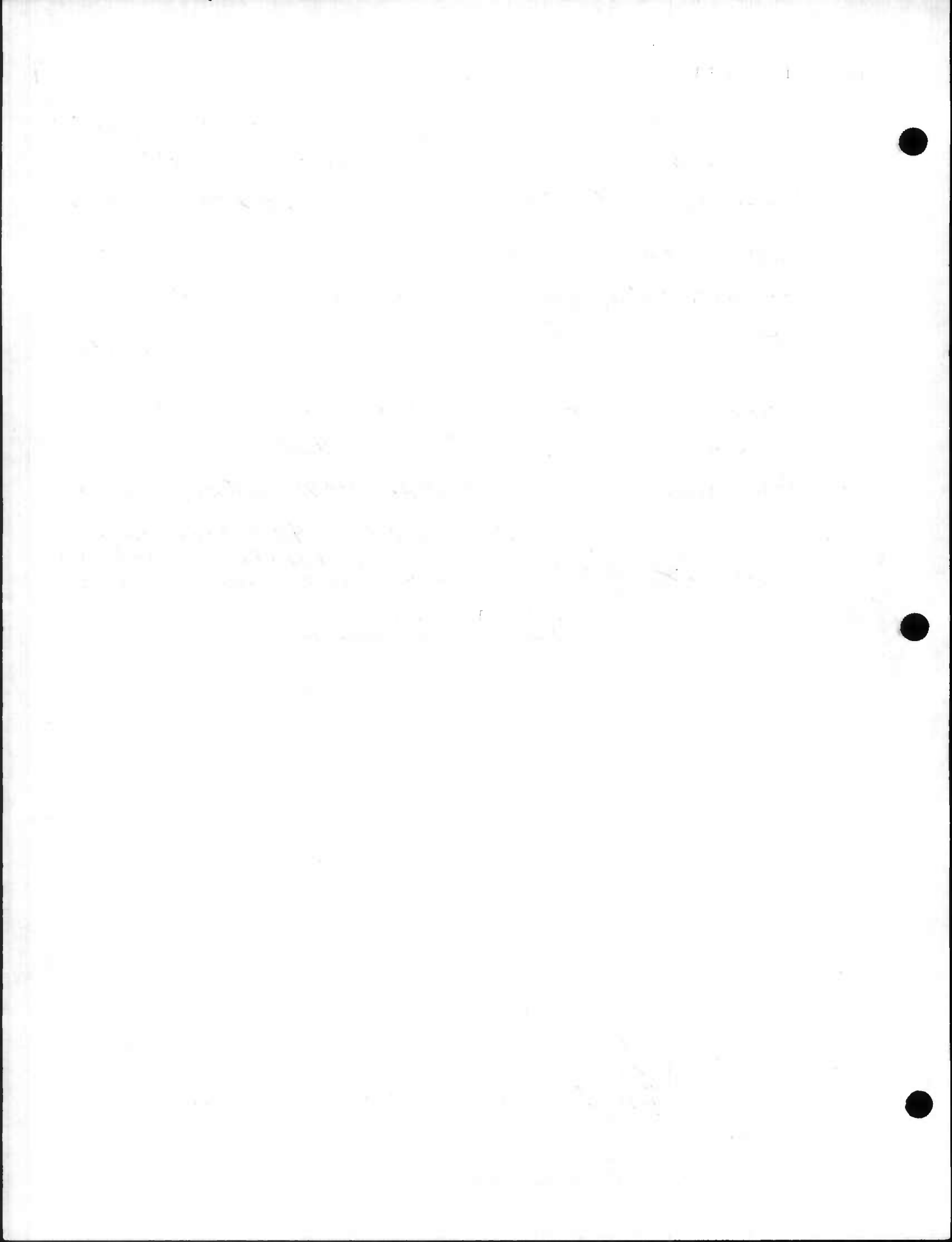
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12588

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOANNA JENNIE F. NEUMAN

2. Date of Death

Month

Day

Year

APRIL

25

1997

3. Time of Death

2:00 pm

4a. Facility Name (If not institution, give street and number)

7428 BRIGHTSIDE AVENUE

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

213206470

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

DEC 18, 1896

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

ROSEDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7428 BRIGHTSIDE AVENUE

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SUNPAPER

16b. Kind of Business/Industry

FOOD SERVICE

17. Father's Name (First, Middle, Last)

JOHN AMEND

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE SCHETTERUM

19a. Informant's Name/Relationship (Type, Print)

CATHERINE STEINACKER/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7428 BRIGHTSIDE AVE ROSEDALE, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

SCHWARTZ CEMETERY

Date

4/28/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CVACH/ROSEDALE FUNERAL HOME  
1211 CHESACO AVENUE BALTO, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *Arteriosclerotic cardiovascular disease*  
Due to (or as a consequence of):b. *Hypertension*  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D35410

29d. Date signed (Month, Day, Year)

4/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.L. Pfeiffer 6918 RIDGE RD. BALTO, MD 21237

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Rendell

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours of death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or "accident," or if item 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 1 4-28-97 Film G746 W.H. Per Doctor

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12589

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Theresa D. Nicolazzo

2. Date of Death  
Month Day Year

4 10 1997

3. Time of Death  
13:08

4a. Facility Name (If not institution, give street and number)

R.A. Cowley Shock Trauma

City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

180-50-4129

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

36

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

MAR-12, 1961

9. Birthplace (State or Country)

PITTSBURGH PA

Usual Residence of Decedent

10a. State

MD.

10b. County

QUEEN ANNE'S

10c. City, Town or Location

STEVENSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

803 MARION QUIMBY ST.

10f. Zip Code

21666

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOME MAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LEONARD BECHTOLD

18. Mother's Name (First, Middle, Maiden Surname)

MARY TRACH

19a. Informant's Name/Relationship (Type, Print)

RITA ANKNEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

229 LOBINGER AVE. N. BRADDOCK, PA 15104

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MONONGAHELA CEM.

Date

APR-14 1997

20c. Location - City or Town, State

N. BRADDOCK, PA.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SKARDA FH 2879 HUDSON ST. BALTIMORE, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Massive Right Subdural Hematoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

4/9/97

28b. Time of Injury

7:00 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Motor Vehicle Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

LAN BUNG ST. BALTO. MD

29a. Certifier (Check only one)

1 ☒ Medical Examiner

2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

MD27163

29d. Date signed (Month, Day, Year)

4/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H.N. Reynolds R.A. Cowley Shock Trauma Center, 72 S. Greene St. Balto, MD

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12590

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |   |  |
|---|---|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>BETTY PHILLIPS</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 24 1997</b>   |  |  |  | 3. Time of Death<br><b>8.05 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>LEVINDALE</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  |  |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-01-9769</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 18, 1905</b>                     |  | 9. Birthplace (State or Foreign Country)<br><b>RUSSIA</b>   |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |  |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   | 10e. Street and Number<br><b>2434 W. BELVEDERE AVE.</b>   |  |   |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>          |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALES PERSON</b>                  |  |  |  | 16b. Kind of Business/Industry<br><b>DEPARTMENT STORE</b>                        |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>MORRIS HOFFMAN</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>FANNIE ARUTSKY</b>   |  |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>PAULA KAUFMAN (DAUG.)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12715 CLEARFIELD DR. BOWIE, MD 20715</b>   |  |  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ANSHE EMUNAH</b>   |  | Data<br><b>4/27/97</b>   |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>                      |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. MULTI-SYSTEM FAILURE</b><br>Due to (or as a consequence of):<br><b>b. VASCULAR DEMENTIA</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>TWO WEEKS</b>  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br><b>SICK SINUS SYNDROME</b>   |  |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicida <input type="checkbox"/> Homicida   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |
|   |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |   |  |
|   | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |   |  |
|   | 29b. Signature and title of certifier<br><b>ATTENDING PHYSICIAN</b>   |  |   |  | 29c. License number<br><b>D25610</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 24 1997</b>                      |  |   |  |
| State<br>Registrar                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LEVINDALE 2434 WEST BELVEDERE AVENUE BALTIMORE MD 21215</b>  |  |   |  |  |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  |   |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 12591

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Barry Anthony PETERSON

2. Date of Death

Month Day Year  
April 22, 1997

3. Time of Death

5:35 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

219-38-4799

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 18, 1940

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☐ No

10e. Street and Number

814 Middlesex Rd.

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Management - Production Printing Industry

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Bradford A. Peterson

18. Mother's Name (First, Middle, Maiden Surname)

Lois Taylor

19a. Informant's Name/Relationship (Type, Print)

Mary Lou Peterson - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

814 Middlesex Rd., Baltimore, MD 21221

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fairview Cemetery

Date

April 26, 1997 Arendtsville, PA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Victor Lengrand, Jr.

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Upper Gastrointestinal Bleed

Minutes

Due to (or as a consequence of):

b. Possible Esophageal tear

Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe atherosclerosis, possible acute myocardial

infarction, old posterior wall myocardial infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Louis Semenoff

29c. License number

D10032

29d. Date signed (Month, Day, Year)

4/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louis Semenoff

2108 Orems Road

Baltimore, Maryland

21220

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Rendall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

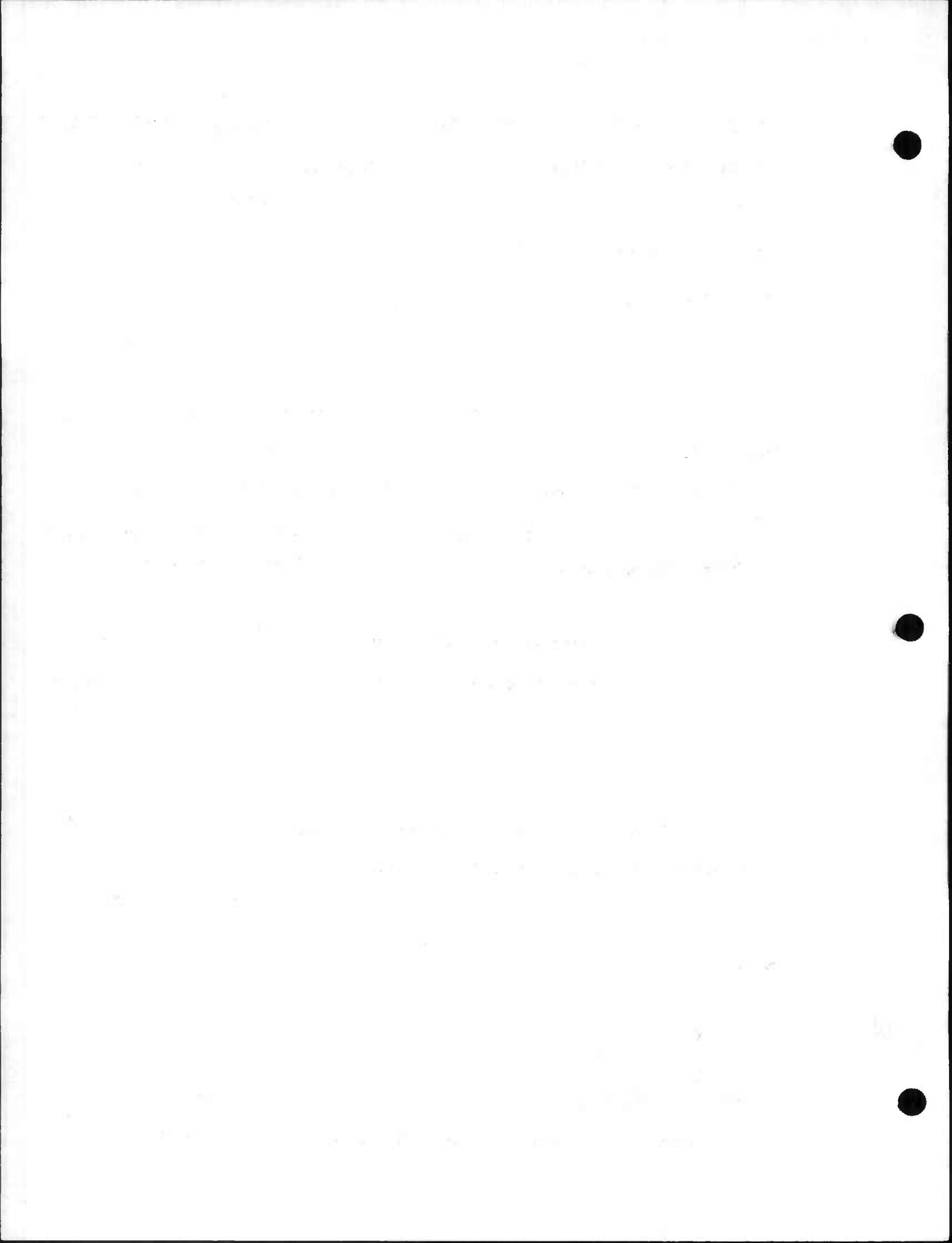
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Health Officer: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



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State of Maryland / Department of Health and Mental Hygiene

97 12592

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Grace Margaret Peltzer

2. Date of Death

Month

Day

Year

April 23

1997

9:12 PM

3. Time of Death

9:12 PM

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

213-46-2213

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 26, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2018 Coon Club Road

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Jacob Helwig

18. Mother's Name (First, Middle, Maiden Surname)

Dora Murray

19a. Informant's Name/Relationship (Type, Print)

Geraldine McQuay/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2018 Coon Club Rd. Westminster, Md. 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pleasant Grove Cem.

Date

4-26-97

20c. Location - City or Town, State

Boring, Maryland

21. Signature of Funeral Service Licensee

Kam B. Elini

22. Name and Address of Facility

11824 Reisterstown Rd.  
ELINE FUNERAL HOME Reisterstown, Md. 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Colon Cancer

Approximate Interval Between Onset and Death

Five Years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thrombophlebitis  
Peptic Ulcer Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Jonathan Kushner MD

29c. License number

033184

29d. Date signed (Month, Day, Year)

April 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Kushner 114 Business Center Drive Reisterstown, MD

State  
Registrar

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

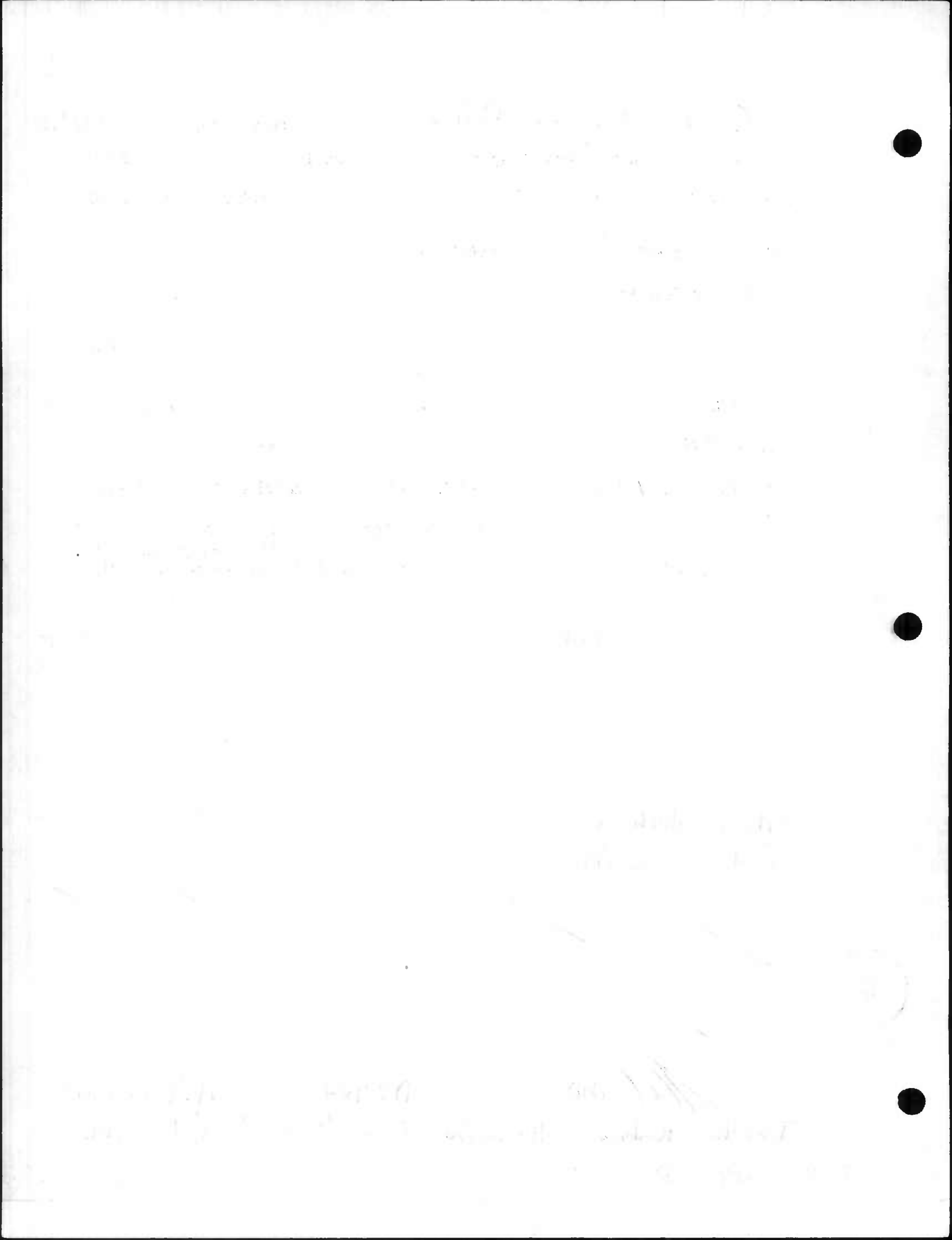
Division of Vital Records, P.O. Box 68760,

To the Hospital certifying physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

97 12593

## Certificate of Death

Reg. No.

|  |   |  |   |   |  |  |   |  |
|--|---|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ann Pascucci</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>April 15, 1997</b>  |  | 3. Time of Death<br><b>7:40 AM</b>                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5227 Patriot Lane</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |  | 4c. County of Death<br><b>Howard</b>                                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>158-24-3467</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 6, 1933</b>               |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>  |  |   |   |  |  |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Howard</b>  |  |
|  | 10c. City, Town or Location<br><b>5227 Patriot Lane, Columbia</b>   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|  | 10e. Street and Number<br><b>5227 Patriot Lane</b>  |  |   |   | 10f. Zip Code<br><b>21045</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>5+</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>teacher</b>                       |   | 16b. Kind of Business/Industry<br><b>school</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Muelbaur</b>   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Johanna Schmitner</b>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard Pascucci/husband</b>  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5227 Patriot Lane, Columbia, Maryland 21045</b>   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | 20c. Location - City or Town, State  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph B. Van Sant</b>   |   |  |   | 22. Name and Address of Facility<br><b>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland, 21201</b>  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>metastatic lung cancer to liver. 9 months</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |  |   |   |  |  |   | Approximate Interval Between Onset and Death |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>N/A.</b>   |  |   |   |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   | 29b. Signature and title of certifier<br><b>QBC</b>   |  | 29c. License number<br><b>D41139</b>   |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>April 18, 97</b>   |   |  |   |   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>12103 Portico Dr Rockville, MD 20852</b>  |   |  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b><br><b>Julia Davidson-Rodriguez</b>   |   |  |   |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

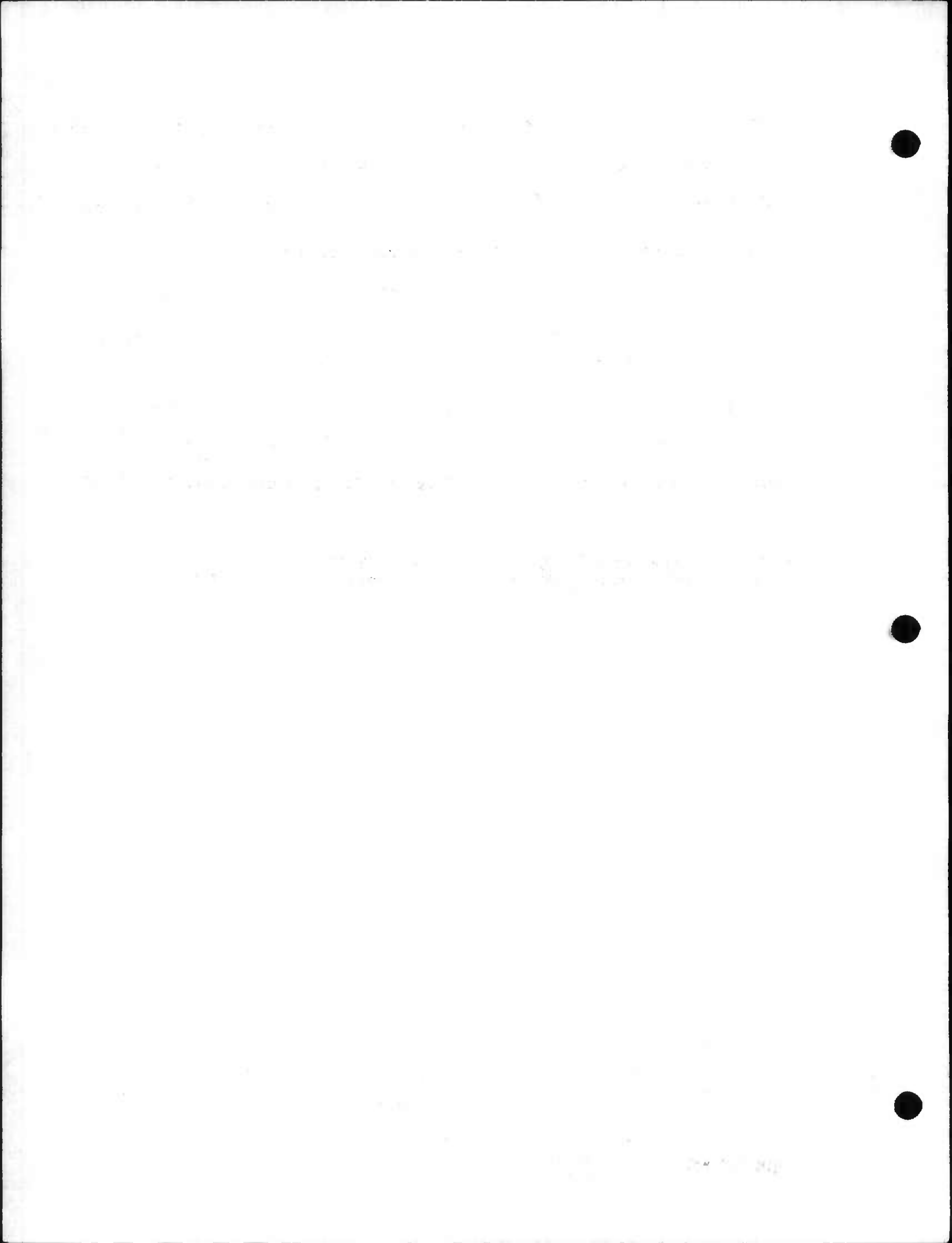
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12594

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jean Rosenbaum

2. Date of Death

Month Day Year  
April 24 1997

3. Time of Death

9:57 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

219-03-4862

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 21, 1909

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1190 W. NORTHERN PARKWAY, APT. 505

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

BENJAMIN

BERKOWITZ

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

ORNOFF

19a. Informant's Name/Relationship (Type, Print)

IRV FLAX

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6808 CHEROKEE DR. BALTO., MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE HEBREW

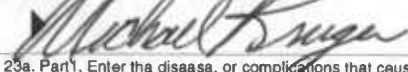
Date

4/27/97

20c. Location - City or Town, State

REISTERSTOWN, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Approximate Interval Between Onset and Death

&gt; 2 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ischemic Heart Disease

&gt; 2 hrs

c. HTN

&gt; 2 hrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DJD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

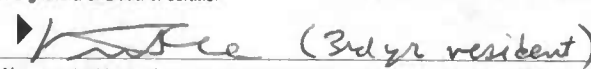
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

 (3rd yr resident)

29c. License number

VL 9833 AS 2402321

29d. Date signed (Month, Day, Year)

April 24, 1997

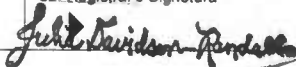
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Vincent Lee, Sinai Hospital 2401 W. Belvedere Ave. Baltimore MD 21215

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death within the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b are marked other than "natural", the Medical Examiner must be notified by phone.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

HW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12595

ITEM:20b per FH G-747 5-2-97 eoh

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH RAIMONDI

2. Date of Death

Month Day Year  
APRIL 25 1997

3. Time of Death

12:50 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

216 14 1234

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 11, 1911

9. Birthplace (State or Foreign Country)

ITALY

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PIKESVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5412 Old Court Rd.

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☒ Yes ☐ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)  
n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dry Cleaning Operator

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Pietro Raimondi

18. Mother's Name (First, Middle, Maiden Surname)

Nicolina Cuccia

19a. Informant's Name/Relationship (Type, Print)

Pietro J. Raimondi - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

738 Dulaney Valley Rd., Towson, MD 21204

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mausoleum

1997 Date

28 APR. 1996

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Lowell M. Lemmon

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.  
10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SEPSIS

Due to (or as a consequence of):

2 WEEKS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DECUBITOUS ULCERS

ORGANIC BRAIN SYNDROME

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K. S. RAO, M.D.

29c. License number

D43462

29d. Date signed (Month, Day, Year)

APRIL 25 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. S. RAO, M.D.  
NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD.

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature  
Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12596

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marjorie Starr Roche

2. Date of Death

Month Day Year  
April 23, 1997

3. Time of Death

7:30am

4a. Facility Name (If not Institution, give street and number)

400 Kilree Court, unit 101

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

214-22-5622

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept 15, 1916

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

400 Kilree Court, unit 101

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank L. Starr

18. Mother's Name (First, Middle, Maiden Surname)

Aline Helen Aman

19a. Informant's Name/Relationship (Type, Print)

William Ronald Roche, Sr./Husband 400 Kilree Ct., unit 101, Timonium, MD 21093

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley Mem. Grdns. 4/26/97 Timonium, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Road, Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. CORONARY DYSRHYTHMIA

Due to (or as a consequence of):

b. PULMONARY EMBOLUS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

m, d

m, d

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOAOther: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

000562

29d. Date signed (Month, Day, Year)

April 24, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Richard Biggs, MD 7505 Osler Dr., suite 509, Towson, MD 21204

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 48 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 8 4-28-97 Film G746 W.H.Per F/H

## Certificate of Death

Reg. No.

97 12597

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Francis RUPPERT

2. Date of Death

April 25, 1997

3. Time of Death

7:35 am

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-14-8679

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 27, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3810 Bayonne Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1944-4513. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Lieutenant

16b. Kind of Business/Industry

Law Enforcement

17. Father's Name (First, Middle, Last)

Louis Ruppert

18. Mother's Name (First, Middle, Maiden Surname)

Anna Schmidt

19a. Informant's Name/Relationship (Type, Print)

Mr. Francis Ruppert, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3810 Bayonne Avenue Baltimore, Md. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forest Md. Vet Cem 4/28/97

Date

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

Mark T. Zavoyna

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Md. 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 Days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

2 Days

c. Bradycardia

Due to (or as a consequence of):

2 Days

d. Hypotension

2 Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Hamilton Small

29c. License number

RD2125

29d. Date signed (Month, Day, Year)

April 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hamilton Small M.D. 9000 Franklin Square Drive, Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

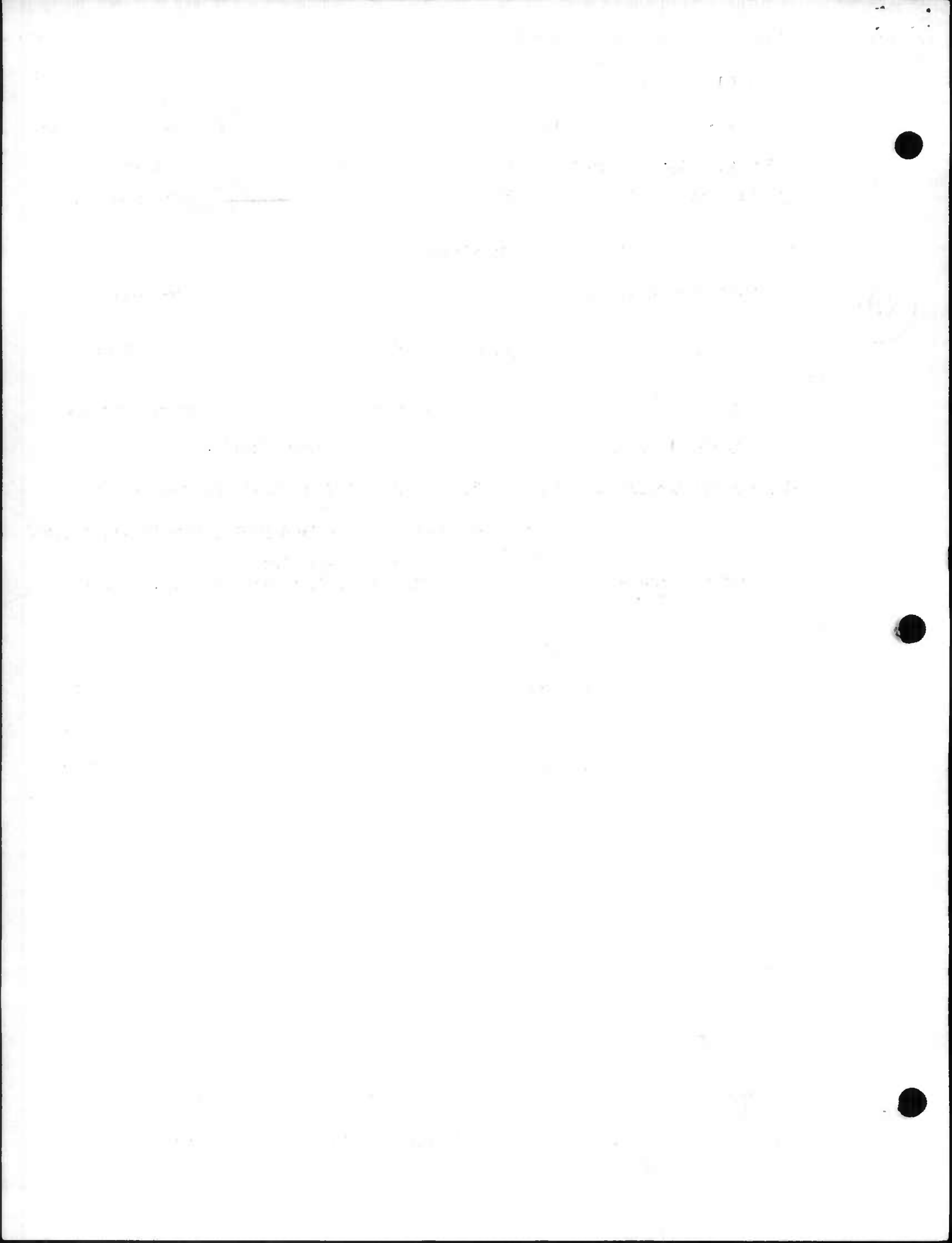
Julia Davidson-Randall

State  
RegistrarBaltimore, Maryland 21215-0029  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12598

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Howard Bruce Richmond, Sr.

2. Date of Death

Month Day Year

APRIL 26 1997

3. Time of Death

15:52

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-28-3806

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 29, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3329 Richmond Ave.

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Insurance Investigator

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Arthur Samuel Richmond

18. Mother's Name (First, Middle, Maiden Surname)

Roberta Mitchell

19a. Informant's Name/Relationship (Type, Print)

Dorothy M. Richmond

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3329 Richmond Ave., Baltimore, MD 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Green Mount Crematory

Date

4/28/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ALTENBURG FUNERAL HOME, P.A.

6009 Harford Rd., Baltimore, MD 21214

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate  
interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Acute Myocardial infarction

Due to (or as a consequence of):

1 hour + 20 min

b.

Respiratory failure

Due to (or as a consequence of):

8 days

c.

Sepsis

Due to (or as a consequence of):

10 days

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

APRIL 26/1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSNY Habashy 201 E. University Parkway, Baltimore, MD 21218

State

Registrar

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death in the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

11/11/54

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

97 12599

Reg. No.

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Nema (First, Middle, Last)<br><b>JERRY ROLES</b>   |  |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>19</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>10:23P.M.</b>   |  |
|   | 4a. Facility Nema (If not institution, give street and number)<br><b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>NA</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-52-4056</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>47</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>07-25-49</b>   |  |
|   | 10e. State<br><b>Md.</b>   |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>4816 Parkside Drive</b>   |  |   |  | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>Na</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Produce Clerk</b>   |  | 16b. Kind of Business/Industry<br><b>Super Fresh Foods</b>                                     |  |
|   | 17. Father's Nema (First, Middle, Last)<br><b>Roland Roles</b>   |  |   |  | 18. Mother's Nema (First, Middle, Maiden Surname)<br><b>Jean Myers</b>  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Nema/Relationship (Type, Print)<br><b>Freida Roles</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21206 4816 Parkside Drive Baltimore, Maryland</b>  |  |  |  |
|   | 20e. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Mem. Pk. Cem 0426-97</b>  |  | 20c. Location - City or Town, State<br><b>Randallstown, Md.</b>                                |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E.</b>   |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 20, 1997</b>   |  |   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MD R. D. M. P. K. 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |
|   | 33. Registrar's Name<br><b>John A. Anderson</b>  |  |   |  | 34. Registrar's Title<br><b>Registrar</b>   |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12600

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES ELAINE RIDLEY

2. Date of Death

Month Day Year  
APRIL 25 1997

3. Time of Death

4:00 AM

4a. Facility Name (If not institution, give street and number)

GENESIS ELDERCARE RANDALLSTOWN

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE COUNTY

5. Social Security Number

227-66-5541

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 4 1948

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5021 A The Alameda

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12Collage (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife/domestic

16b. Kind of Business/Industry

Home Owner

17. Father's Name (First, Middle, Last)

William C. Everett

18. Mother's Name (First, Middle, Maiden Surname)

Missouri L. Hill

19a. Informant's Name/Relationship (Type, Print)

Felicia Ridley/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5021 A The Alameda, Baltimore, Md. 21239

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Gilead Amez Church Cemt.

Date

4/29/97

20c. Location - City or Town, State

Southampton Co. Virg.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully Funeral Home of South Baltimore  
130 E. Fort Ave., Baltimore, Md. 2123023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Metastatic Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1. Chronic Schizophrenia

2. Hypertension.

3. Urinary tract infection.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35674

29d. Date signed (Month, Day, Year)

April 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda J. Clemmings 4920 Seaton Drive Suite A Poxet Md 21215

31. Date filed (Month, Day, Year)

APR 28 1997

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", item 28a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12601

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br><b>CATHERINE REISIG</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 21 1997</b>   |  | 3. Time of Death<br><b>09:15 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SAINT JOSEPH MEDICAL CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON, MARYLAND</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director                              | 5. Social Security Number<br><b>24-01-4486</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 28, 1909</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Parkville</b>   |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>8515 Old Harford Rd. Apt. F</b>  |  | 10f. Zip Code<br><b>21234</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10 yrs.</b> College (1-4 or 5+) <b>—</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>                         |  | 16b. Kind of Business/Industry<br><b>Exxon Com.</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>John J. Reisiq</b>  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna C. Betz</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Kraus</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>niece 3811 Echodale Ave. Baltimore, Md 21206</b>   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                     |  |
| Physician<br>/Medical<br>Examiner                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart of Jesus</b>   |  | 20c. Location - City or Town, State<br><b>April 25, 1997 Dundalk, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |  | 22. Name and Address of Facility<br><b>Evans Chapel of Memories 8800 Harford Rd. Baltimore, Md 21234</b>  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>PULMONARY EMBOLISM</b><br>Due to (or as a consequence of):<br><br>b. <b>ABDOMINAL MASS</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><br><b>20 HOURS</b><br><br><b>06 HOURS</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by<br>Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                 |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |
|  | 28a. Date of Injury (Month, Day, Year)<br><b>April 21 1997</b>   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
| State<br>Registrar                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |
|  | 29c. License number<br><b>D21207</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/24/97</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FRANZ, VELLA-CAMILLERI, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or "accident," the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12602

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY RUSSUM

2. Date of Death  
Month Day Year

APRIL 22, 1997

3. Time of Death

6:25PM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

222-07-5307

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 22, 1911

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10e. State  
Maryland Baltimore

10b. County

10c. City, Town or Location  
Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13 Evans Ave.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
4 yrs.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

mechanic

16b. Kind of Business/Industry

Greggo & Ferrare

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Muriel Russum wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 Evans Ave Timonium, Md 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel - Bel Air

Date

April 23, 1997

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensed

[Signature]

22. Name and Address of Facility

Evans Chapel of Chimes

2325 York Rd. Timonium, Md 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

COPD

Due to (or as a consequence of):

CHF

Due to (or as a consequence of):

Aspiration pneumonia

Due to (or as a consequence of):

Diabetes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure  
Metastatic prostate cancer  
Pulmonary Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D25259

29d. Date signed (Month, Day, Year)

4/23/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David Berline

6569 N. Chader ST Suite 600 21204

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or the cause of death shows any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12603

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Ribero

2. Date of Death

April 17 1997

3. Time of Death

1:40PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

215-28-7331

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 15, 1920

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Woodlawn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6613 Windsor Mill Road

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

General Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Giuseppe Ribero

18. Mother's Name (First, Middle, Maiden Surname)

Margherita Miglia

19a. Informant's Name/Relationship (Type, Print)

Joseph Ribero (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13800 Russell Zepp Drive Clarksville, Maryland 21029

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Entombment Lorraine Park Mausoleum

Date

April 21, 1997

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.  
1630 Edmondson Avenue Catonsville, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Proliferative vascular disease  
Old cerebral vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19502

29d. Date signed (Month, Day, Year)

April 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORLANDO B. CONNAN M.D.

NORTHWEST HOSPITAL CENTER  
RANDALLSTOWN MD. 21133State  
Registrar

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Baltimore, Maryland 21201-1500  
permit. Pages 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

HW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12604

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE

D.

SAUNDERS

2. Date of Death

APRIL 26, 1997

3. Time of Death

12:55 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

5. Social Security Number

566 20 5064

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 2, 1903

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State  
Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2226 Crest Rd.

10f. Zip Code

21209

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

Meat Packing Company

17. Father's Name (First, Middle, Last)

Clifford

Dunhan

18. Mother's Name (First, Middle, Maiden Surname)

Jessie

Osborne

19a. Informant's Name/Relationship (Type, Print)

Anneke Davis / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2226 Crest Rd., Baltimore, MD 21209

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 4/29/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.

8717 Green Pastures Dr., Baltimore, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. SEPTIC SHOCK

Due to (or as a consequence of):

b. UROSEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1. DEHYDRATION

2. CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 37254

29d. Date signed (Month, Day, Year)

4/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

State  
Registrar

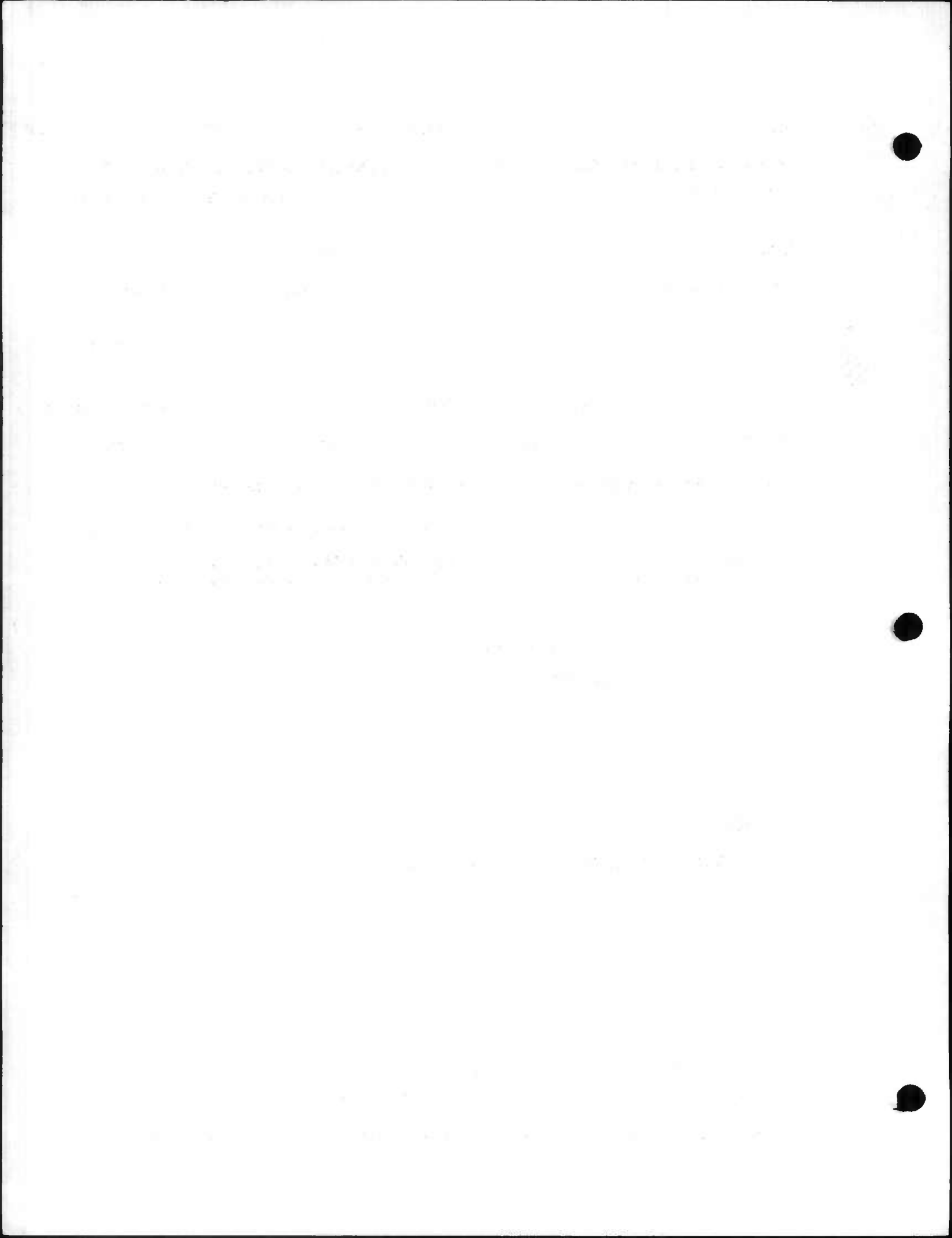
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than Natural, 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12605

Item10e 4-28-97 FilmG746 W.H.Per F/H

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Rebecca Sanders</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>24</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>07:30am</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MD HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-40-2647</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 28, 1912</b>  |  |
|   | Usual Residence of Decedent   |  | 10e. State<br><b>MD</b>   |  | 10b. County<br><b>BALTO.</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>13 POMONA SOUTH, APT. 5</b>  |  | 10f. Zip Code<br><b>21208</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b> <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TEACHER</b>   |  | 16b. Kind of Business/Industry<br><b>EDUCATION</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>PHILIP REISMAN</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROSE LANDY</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARTIN SANDERS (HUS.)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13 POMONA SOUTH, APT. 5 BALTO., MD 21208</b>   |  |  |  |
|   | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETH EL MEM. PARK</b>  |  | Date<br><b>4/25/97</b>   |  | 20c. Location - City or Town, State<br><b>RANDALLSTOWN, MD</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Allen Lee Levenson</b>  |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>  |  |  |  |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>bilateral pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>aspiration</b><br>Due to (or as a consequence of):<br>c. <b>Cerebrovascular accident</b><br>Due to (or as a consequence of):<br>d. <b>hypertension</b> |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><br><b>one month</b> |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how Injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>MD</b>  |  |   |  | 29c. License number<br><b>P10228</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 24 1997</b>  |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Denise Hodgson University of Maryland Hospital 22 South Greene Street Baltimore, MD 21201</b>  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  |   |  | 32. Registrar's Signature<br><b>J. A. Henderson</b>  |  |  |  |
|   |   |  |   |  |  |  |  |  |

1948



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12606

## Certificate of Death

Reg. No.

|  |  |  |  |   |   |   |  |   |  |
|--|--|--|--|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JACK STERN</b>  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 24 1997</b>  |   | 3. Time of Death<br><b>2 PM</b>                            |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>4603 HORIZON CIRCLE, APT. 3</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b> |   | 4c. County of Death<br><b>BALTIMORE</b>                    |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-01-7652</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 8, 1916</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>                                      |  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>BALTIMORE</b>                             |   | 10c. City, Town or Location<br><b>RANDALLSTOWN</b>         |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>4603 HORIZON CIRCLE, APT. 3</b>  |   | 10f. Zip Code<br><b>21133</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PAINT DEPARTMENT</b>   |  | 16b. Kind of Business/Industry<br><b>KITCHEN CABINETS</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>PHILLIP STERN</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNA GAYLOR</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HARRY STERN (BRO.)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2500 W. BELVEDERE AVE., APT. 205 BALTO., MD 21215</b>  |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERANS</b>  |  | 20c. Location - City or Town, State<br><b>OWINGS MILLS, MD</b>          |  |
| 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>  |  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Cardio-pulmonary arrest</b><br>Due to (or as a consequence of):<br><br>b. <b>emphysema</b><br>Due to (or as a consequence of):<br><br>c. <b>cigarette smoking</b><br>Due to (or as a consequence of):<br><br>d. |   | Approximate Interval Between Onset and Death  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>D33785</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4-25-97</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Jeffrey Harsley MD Rt 33127 10 N. Green St Baltimore MD 21201</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |  | Registrar's Signature<br><b>[Signature]</b>   |   |   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than natural, items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12607

Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Florence Staples</i>   |   |   | 2. Date of Death<br>Month <i>April</i> Day <i>24</i> Year <i>1997</i>  |  | 3. Time of Death<br><i>05:00pm</i>   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Sinai Hospital</i>   |   |   | 4b. City, Town, or Location of Death<br><i>Baltimore</i>   |  | 4c. County of Death<br><i>NA</i>   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>219-12-8313</i>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>73</i> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><i>12-9-1923</i>                              |  |  |
|  | Usual Residence of Decedent   |   | 9. Birthplace (State or Foreign Country)<br><i>Md</i>   |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><i>Md</i>   |   | 10b. County<br><i>NA</i>  |  | 10c. City, Town or Location<br><i>Baltimore</i>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><i>3917 Oakford Avenue</i>  |   |   | 10f. Zip Code<br><i>21215</i>  |  | 10g. Citizen of What Country?<br><i>U.S.A</i>  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>                            |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th grade</i><br>College (1-4 or 5+) <i>NA</i>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Home care</i>                         |  | 16b. Kind of Business/Industry<br><i>Elderly People</i>  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><i>Brian Summers</i>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Margaret Cannon</i>  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Charles M. Staples Son</i>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3401 Garrison Blvd Apt A7 Baltimore, Md 21215</i> |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>King Memorial Park</i>   |  | 20c. Location - City or Town, State<br><i>4-28-97 Randallstown, Md</i>   |  | 20d. Date  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Sharon Stines</i>   |   |   | 22. Name and Address of Facility<br><i>March F.H. West 4300 Wabash Avenue Baltimore, Md 21225</i>  |  |  |  |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |   |   |  |  |  | Approximate Interval Between Onset and Death   |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br><i>Major Cardiovascular Accident</i>   |   |   |  |  |  | <i>5 days</i>  |  |
|  | Due to (or as a consequence of):<br><i>Hypertension</i>   |   |   |  |  |  | <i>15 years</i>  |  |
|  | Due to (or as a consequence of):  |   |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |   |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Diabetes Mellitus, Non-Insulin Dependent</i><br><i>Osteoarthritis</i>   |   |   |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|  |   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |
|  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Beverly M. Carkins, M.D.</i>   |   | 29c. License number<br><i>6C9021</i>  |   | 29d. Date signed (Month, Day, Year)<br><i>April 24, 1997</i>   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>Beverly M. Carkins, M.D., Sinai Hospital, 2401 West Belvedere Avenue, Baltimore, Md 21215</i>   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 28 1997</i>  |   | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12608

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Ray Nelson Showman

2. Date of Death

Month Day Year

April 25, 1997

3. Time of Death

8:30pm

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

020-60-1919

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

32

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 12, 1965

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Finksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8 E. Collins Circle

10f. Zip Code

21048

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

construction worker

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

Nelson Showman

18. Mother's Name (First, Middle, Maiden Surname)

Billie Montour Laferte

19a. Informant's Name/Relationship (Type, Print)

Bille M. Laferte / mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

276 Salmon Falls Rd, Rochester, N.H. 03868-5709

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation

Date

4/29/97

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

Iffly B. Eli

22. Name and Address of Facility

11824 Reisterstown Rd  
Eline Funeral Home Reisterstown, MD 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumocystis CARinii Pneumonia

Approximate Interval Between Onset and Death

2 weeks

Due to (or as a consequence of):

Acquired Immuno Deficiency Syndrome

4 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute liver failure

Acute renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

I Thomas K. Galvin M.D.

29c. License number

D31660

29d. Date signed (Month, Day, Year)

4/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

I Thomas K. Galvin M.D. 295 STONER AVE. WESTMINSTER MD

State  
Registrar

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

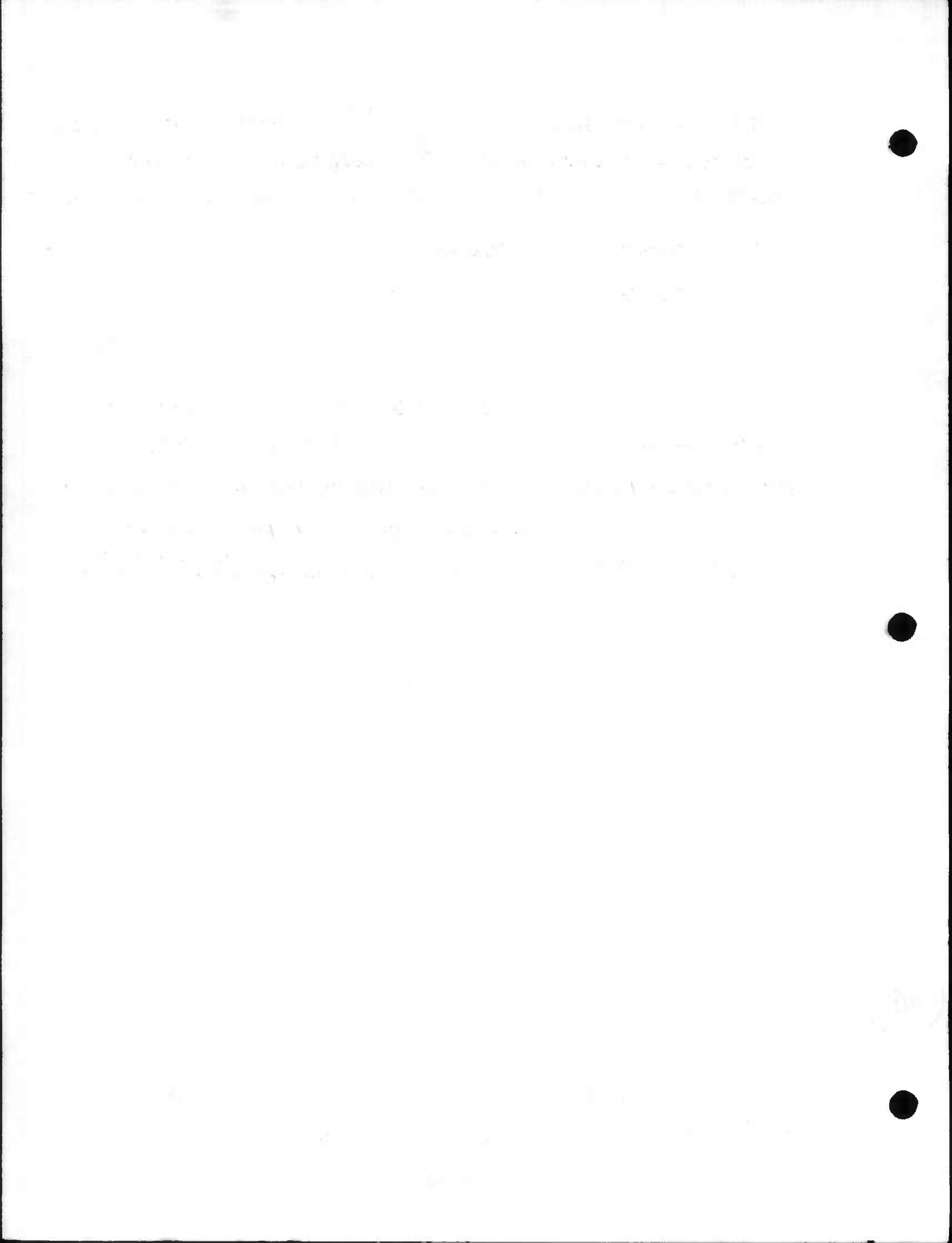
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transfer permit.

Division of Vital Records, P.O. Box 68760,





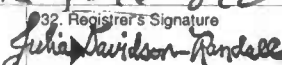
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12609

|  |  |                                 |   |   |  |  |   |  |  |
|--|--|---------------------------------|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Blanche B. Schultz</b>                                    |                                 |   |   | 2. Date of Death<br>Month <b>April</b> Day <b>26</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>9:40 am.</b>                                     |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Cherrywood Extended Health Care</b> |                                 |   |   | 4b. City, Town, or Location of Death<br><b>Reisterstown</b>  |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>442-07-8077 D</b>  |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>April 14, 1901</b>            | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|  | Usual Residence of Decedent  |                                 |   |   |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b> |   | 10c. City, Town or Location<br><b>Reisterstown</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 10e. Street and Number<br><b>51 Hanover Rd.</b>  |  |                                 |   | 10f. Zip Code<br><b>21136</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)   |  |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  | 16b. Kind of Business/Industry<br><b>Homemaker</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edward L. Brillhart</b>  |  |                                 |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eliza J. Klinefelter</b>  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Edward Schultz - Son</b>  |  |                                 |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>51 Hanover Rd. Reisterstown, Md. 21136</b>  |  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cem.</b>   |   | Date<br><b>April 30, 1997</b>  |  | 20c. Location - City or Town, State<br><b>Pikesville, Md.</b>           |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |                                 |   | 22. Name and Address of Facility<br><b>Eckhardt Funeral Chapel</b><br><b>11605 Reisterstown Rd. Owings Mills, Md. 21117</b>   |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><b>Post-operative Abdominal Infection</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Alzheimer's Dementia</b><br>Due to (or as a consequence of): |  |                                 |   |   |  |  |   | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Dementia</b>  |  |                                 |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |                                 |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |                                 |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                 |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |                                 |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |                                 |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |   |  |  |
|  |  |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |                                 |   |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br>   |  |                                 |   | 29c. License number<br><b>039050</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/28/97</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>1838 Green Tree Rd Pikesville MD 21208</b>  |  |                                 |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |  |                                 |   | 32. Registrar's Signature<br>  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

97 12610

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRELENA

SCHMIDT

2. Date of Death

Month

Day

Year

APRIL 25, 1997

3. Time of Death

2:40 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

FRANKLIN SQUARE Hospital Center

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

5. Social Security Number

213-60-7453

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG 12, 1913

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE, CO. MARYLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3003 MORELAND AVE

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8thCollege (1-4 or 5+)  
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

CHARLES BIENSACK

18. Mother's Name (First, Middle, Maiden Surname)

LENA WOLF

19a. Informant's Name/Relationship (Type, Print)

GLADYS LANKFORD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

71 Marie Ct. Kendall - PK. N.J 08824

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

4/29/97

20c. Location - City or Town, State

BALT, MD.

21. Signature of Funeral Service Licensee

Jody D. Smith

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME  
7527 HARTFORD RD. BALT, MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Cardiac arrest

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

b.

Cardiovascular disease

Due to (or as a consequence of):

Years

c.

Hypertension

Due to (or as a consequence of):

Years

d.

Sick Sinus Syndrome

Due to (or as a consequence of):

1 1/2 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Susan Weiner

29c. License number

D 34941

29d. Date signed (Month, Day, Year)

April 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SUSAN G. WEINER MD 5601 Loch Raven BLVD. BALTIMORE, MD 21239

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 4 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12611

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gerald Sparks

2. Date of Death

Month  
April

Day

27

Year

1997

3. Time of Death

7:53 AM

4a. Facility Name (If not institution, give street and number)

Lorien Riverside Nursing Center

4b. City, Town, or Location of Death

Belcamp

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

235-20-0462

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

August 1, 1922

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppatowne

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

618 Harborside Drive

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Purchasing Agent

16b. Kind of Business/Industry

Westinghouse Co.

17. Father's Name (First, Middle, Last)

William A. Sparks

18. Mother's Name (First, Middle, Maiden Summa)

Maggie Neff

19a. Informant's Name/Relationship (Type, Print)

Sheryl Brock (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

618 Harborside Drive Joppatowne, Md. 21085

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Crematory 4/28/1997

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.

1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending Investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner

29b. Signature and title of certifier

Physician Mh

29c. License number

D46412

29d. Date signed (Month, Day, Year)

4/28/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

319 S. Union Ave Harford DE GRANGE MD 2078

31. Date filed (Month, Day, Year)

APR 28 1997

Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural cause," or 28e shows any injury or other traumatic event, the Medical Examiner must be notified at once.

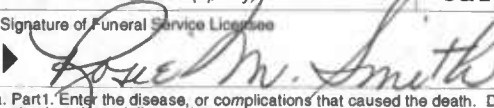
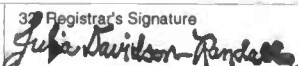
Medical Certification: To Be Completed by Physician/Medical Examiner



## Certificate of Death

97 12612

Reg. No.

|  |   |  |   |   |  |   |  |  |
|--|---|--|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL SHIELDS</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 24, 1997</b>  |   | 3. Time of Death<br><b>12:45 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>526 EAST COLDSRING LANE</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   | 4c. County of Death<br><b>NA</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-62-1621</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br><b>40</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>10-08-56</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>  |  |   |   |  |   |  |  |
| To Be Completed by<br>Funeral Director   | Usual Residence of Decedent   |  |   |   |  |   |  |  |
|  | 10a. State<br><b>Md</b>   |  | 10b. County<br><b>Na</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>526 E. Coldspring Lane</b>   |  |   |   | 10f. Zip Code<br><b>21212</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>Na</b>  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electrician</b>  |   | 16b. Kind of Business/Industry<br><b>A.T.I. Company</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Elmer S. Shields</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mae H. Harris</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Creola Harris</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1625 E. LaFayette Avenue Baltimore, Maryland 21213</b>                                   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest VA Cem. 04-29-97 Owings Mills,</b>  |   | 20c. Location - City or Town, State<br><b>Md.</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C March FH 1101 E. North Avenue</b>  |   |  |  |
|  | Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>NARCOTIC INTOXICATION</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |   |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |  |   |   |  |   |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND 4-24-97</b>   |   | 28b. Time of Injury<br><b>FOUND 12:25</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred<br><b>UNKNOWN</b>  |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND IN HOUSE</b>   |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>526 E/ COLDSRING LANE BALTIMORE, MARYLAND</b>   |   |  |   |   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |  |   |  |  |
| 29b. Signature and Title of Certifier<br>   |   |  |   | 29c. License number<br><b>O.C.M.E</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 25, 1997</b>                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |   |   |  |   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |  |   |   | 32. Registrar's Signature<br>   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12613

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ERHARDT

Smitsdorf

2. Date of Death

Month Day Year

April 24, 1997

3. Time of Death

0030

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

219-12-6149

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 20, 1913

9. Birthplace (State or Foreign Country)

Denmark

Usual Residence of Decedent

10e. State

MD.

10b. County

Baltimore County

10c. City, Town or Location

Baltimore (Baltimore Highlands)

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2821 Florida Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

0

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Longshoreman

16b. Kind of Business/Industry

Atlantic Gulf

17. Father's Name (First, Middle, Last)

Henrikar Schmidtsdorff

18. Mother's Name (First, Middle, Maiden Surname)

Anna Marie Unknown

19e. Informant's Name/Relationship (Type, Print)

Phyllis White( Daughter )

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39 Cedar Road Selbyville, Delaware 19975

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

Date

4/26/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Kevin E. Ecker

22. Name and Address of Facility

McCully Funeral Home of Brooklyn

237 E. Patapsco Ave. Balto., MD. 21225

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 DAYS

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

5 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Constrictive Heart Failure

Chronic Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

5 ☐ Pending investigation

2 ☐ Accidental

6 ☐ Could not be determined

3 ☐ Suicide

4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven E. Heston, MD

29c. License number

D40715

29d. Date signed (Month, Day, Year)

4/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven E. Heston, MD

403 Quincey St.

Salisbury, Md. 21801

31. Date filed (Month, Day, Year)

APR 28 1997

State Registrar

Baltimore, Maryland 21201  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

11W



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12614

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AUDREY

SWITZER

2. Date of Death

Month Day Year  
APRIL 22, 1997

3. Time of Death

3:50 AM

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

220-03-3537

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Aug 18, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8317 Old Harford Rd.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9 yrs.

College (1-4 or 5+)

College

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Packer

16b. Kind of Business/Industry

Maryland Cup

17. Father's Name (First, Middle, Last)

William Carson

18. Mother's Name (First, Middle, Maiden Surname)

Verna Harmon

19a. Informant's Name/Relationship (Type, Print)

Deborah Switzer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8317 Old Harford Rd Parkville, Md 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Evans Funeral Chapel - Bel Air April 23, 1997 Forest Hill, Maryland

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Evans Chapel of Memories  
8800 Harford Rd. Parkville, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

INTRACEREBRAL HEMORRHAGE

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D37254

29d. Date signed (Month, Day, Year)

4/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

[Signature]

State  
RegistrarBaltimore, Maryland 21215-0826  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12615

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |   |   |  |
|--|--|---|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>INGRID MARIA THIELL</b>   |   |   |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>23</b> , Year <b>1997</b>  |   | 3. Time of Death<br><b>3:05PM</b>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>                                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-70-2283</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 2 1927</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>   |
|  | Usual Residence of Decedent  |   |   |   |  |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>Monkton</b>   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No        |   |  |
|  | 10e. Street and Number<br><b>3939 Stansbury Mill Road</b>  |   |   | 10f. Zip Code<br><b>21111</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Raimund Muschkiet</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria Korgel</b>   |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Warren W. Thiell/Husband</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3939 Stansbury Mill Rd., Monkton, MD 21111</b>   |   |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>4/26/97</b><br><b>St. John's Evangelical Luth.Ch.Cem. Sweet Air, MD</b>  |   | 20c. Location - City or Town, State  |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Lowell M. Lemmon</i>   |   | 22. Name and Address of Facility<br><b>Lemmon Funeral Home</b><br><b>10 W. Padonia Rd., Timonium, MD 21093</b>  |   |  |   |   |  |
|  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Ventricular Tachycardia</b><br><b>Coronary Artery Disease</b><br><b>Conduction System Pathology</b> |   |   |   |  |   |   | Approximate Interval Between Onset and Death   |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |   |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe COPD</b>   |  |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred  |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>James Ricely, M.D.</i>  |   | 29c. License number<br><b>H 18752</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/24/97</b>   |   |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>James Ricely, M.D. 6701 N. Charles St., Towson, MD 21204</b>  |  |   |   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12616

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |                                |   |   |
|---|---|--|--|--|--|--------------------------------|---|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><i>Thomas, Tyson</i>  |  |  |  | 2. Date of Death<br>Month <i>April</i> Day <i>25</i> Year <i>1997</i>  |                                | 3. Time of Death<br><i>1:43 AM</i>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Shari Hospital</i>   |  |  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>   |                                | 4c. County of Death<br><i>Baltimore City</i>  |   |
| Funeral<br>Director                           | 5. Social Security Number<br><i>237-18-1644</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><i>83</i> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><i>Dec. 29, 1913</i>                                 | 9. Birthplace (State or Foreign Country)<br><i>N. Carolina</i>  |
|   | Usual Residence of Decedent   |  |  |  |  |                                |   |   |
| To Be Completed by Funeral Director           | 10a. State<br><i>MD</i>   |  | 10b. County<br><i>NA</i>   |  | 10c. City, Town or Location<br><i>BALTIMORE</i>  |                                |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 10e. Street and Number<br><i>4810 LANIER AVE</i>  |  |  |  | 10f. Zip Code<br><i>21215</i>  |                                | 10g. Citizen of What Country?<br><i>USA</i>   |   |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>                     |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>7th</i> College (1-4or 5+) <i>NA</i>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>WELDER</i>   |  | 16b. Kind of Business/Industry<br><i>MD Ship Building</i>  |                                |   |   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><i>WELL TYSON</i>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>ANNIE JOHNSON</i>  |                                |   |   |
|   | 19a. Intormant's Name/Relationship (Type, Print)<br><i>MARTHA TYSON-wife</i>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4810 LANIER AVE. Balto. md. 21215</i>  |                                |   |   |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Woodlawn Cemetery</i>   |  | Date<br><i>4-30-97</i>   |                                | 20c. Location - City or Town, State<br><i>Baltimore Co. MD</i>                              |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Blynn B. Harris</i>   |  |  |  | 22. Name and Address of Facility<br><i>March Funeral Home - West 1300 Wabash Ave. Balto. md. 21215</i>   |                                |   |   |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |                                |   | Approximate Interval Between Onset and Death  |
|   | Immediate Cause (Final disease or condition resulting in death)<br>a. <i>- Acute MI</i><br>Due to (or as a consequence of):<br>b. <i>- Sepsis</i><br>Due to (or as a consequence of):<br>c. <i>-</i><br>Due to (or as a consequence of):<br>d. <i>-</i><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |                                |   | <i>&gt; 24"</i><br><i>- 12"</i>   |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>ischemic (R) Leg.</i>  |  |  |  |  |                                |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |                                |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |   |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |   |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                 |  |  |  |  |                                |   |   |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><i>Vincent Lee Medical resident</i>  |  |  |  | 29c. License number<br><i>AS 240 2321 VL</i>   |                                | 29d. Date signed (Month, Day, Year)<br><i>April 25, 1997</i>                                |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Vincent Lee, 2401 W. Belvedere Ave, Baltimore MD 21215</i>   |  |  |  |  |                                |   |   |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><i>APR 28 1997</i>   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |  |  |                                |   |   |
|   |   |  |  |  |  |                                |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12617

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

June Louise Vaughan

2. Date of Death

April 24, 1997

3. Time of Death

8:00 am

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

1632 "H" Rickenbacher Road

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

5. Social Security Number

210 03 0751

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 6, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1632 "H" Rickenbacher Road

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Key Punch Operator

16b. Kind of Business/Industry

Steel Co.

17. Father's Name (First, Middle, Last)

James Murray

18. Mother's Name (First, Middle, Maiden Surname)

Ethel (Unknown)

19a. Informant's Name/Relationship (Type, Print)

John W. Vaughan (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7823 Fairgreen Rd. Balto., Md. 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greenmount Crematory 4/26/1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bruzdinski Funeral Home P.A.  
1407 Old Eastern Avenue Essex, Md 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. End stage Emphysema.  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

7 years.

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANAYIOTIS, A. BALTAZIS MD, 1232 RACE ROAD SUITE 202 BALTO MD 21237

31. Date filed (Month, Day, Year)

APR 28 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12618

|  |   |   |   |  |  |  |  |   |  |
|--|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Nathanial Wingo</i>  |   |   |  | 2. Date of Death<br>Month <i>4</i> Day <i>23</i> Year <i>97</i>  |  | 3. Time of Death<br><i>4:15 am</i>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>University Hospital</i>  |   |   |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>   |  | 4c. County of Death<br><i>NA</i>   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>217-40-7609</i>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><i>51</i> Yrs.                             | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><i>July 27, 1945</i>                                    | 9. Birthplace (State or Foreign Country)<br><i>N.C.</i> |  |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><i>MD</i>   |   | 10b. County<br><i>NA</i>  |  | 10c. City, Town or Location<br><i>Baltimore</i>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><i>302 N. Chapelgate</i>  |   |   |  | 10f. Zip Code<br><i>21229</i>  |  | 10g. Citizen of What Country?<br><i>U.S.A</i>  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>                        |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8th grade</i> College (1-4or 5+) <i>NA</i>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Clothing Supervisor</i>           |  | 16b. Kind of Business/Industry<br><i>Joseph A. Banks</i>   |  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Nathanial L. Wingo, Sr</i>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><i>Vermella Vandross</i>  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Anita F. Wingo-Exwife</i>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1812 Harlem Avenue Baltimore, MD 21247</i>   |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Woodlawn Cemetery</i>  |  | 20c. Location - City or Town, State<br><i>4-28-97 Baltimore, MD</i>  |  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Shane Stokes</i>  |   |   |  | 22. Name and Address of Facility<br><i>March F.H. West 4300 Wabash Avenue Baltimore, MD 21245</i>  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |   |   |  |  |  |  |   |  |
|  | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                            |   |   |  |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Immediate Cause (Final disease or condition resulting in death)<br><i>cerebral herniation</i>   |   |   |  | Due to (or as a consequence of):   |  |  |   |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>stroke</i>   |   |   |  | Due to (or as a consequence of):   |  |  |   |  |
|  | <i>middle cerebral artery occlusion</i>   |   |   |  | Due to (or as a consequence of):   |  |  |   |  |
|  |   |   |   |  |  |  |  |   |  |
|  |   |   |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>subarachnoid hemorrhage</i>   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
|  |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                       |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Mark E. Lewis</i>  |   |   |   | 29c. License number<br><i>P10036</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>4/23/97</i>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Barbara E. Lazio, MD 22 S. Greene St, Baltimore MD 21201</i>  |   |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 28 1997</i>  |   | 32. Registrar's Signature<br><i>Jane Davidson-Randall</i>   |   |  |  |  |  |   |  |

Baltimore, Maryland 21216-0029  
permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a-f per ME0 G-747 5/1/97 <sup>Feb</sup> Certificate of Death

Reg. No.

97 12619

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
|--|--|--|--------------------------------|--|--|---|---|--|---|-------------------------------------|--|-------------------------------------|--|-------------------------------------|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>STEVIE WHEELER</b>  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 19, 1997</b>  |                                | 3. Time of Death<br><b>2034 PM</b>   |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL E.R.</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                | 4c. County of Death<br><b>NA</b>   |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 5. Social Security Number<br><b>214-78-1759</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>34</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>05-20-62</b> |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 9. Birthplace (State or Foreign Country)<br><b>MD.</b>   |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| Usual Residence of Decedent  |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 10a. State<br><b>Md.</b>   | 10b. County<br><b>NA</b>   | 10c. City, Town or Location<br><b>Baltimore</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 10e. Street and Number<br><b>1007 Mount Street</b>   |  | 10f. Zip Code<br><b>Baltimore</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th Grade</b><br>College (1-4 or 5+) <b>NA</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>  |                                | 16b. Kind of Business/Industry<br><b>various trades</b>  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Willie Wheeler</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Reginia Stevie</b>   |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anthony Malloy</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21237 2209 O'Dell Avenue Baltimore, Maryland</b>  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery 04-26-97</b>  |                                | 20c. Location - City or Town, State<br><b>Lansdowne, Md.</b>   |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue</b>   |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| <table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>e. <b>NARCOTIC AND ALCOHOL INTOXICATION</b></td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td rowspan="4">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table> |  |  |                                |  |  | Immediate Cause (Final disease or condition resulting in death) | e. <b>NARCOTIC AND ALCOHOL INTOXICATION</b> | Approximate Interval Between Onset and Death | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): |  | c. Due to (or as a consequence of): |  | d. Due to (or as a consequence of): |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  | e. <b>NARCOTIC AND ALCOHOL INTOXICATION</b>                                | Approximate Interval Between Onset and Death   |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. Due to (or as a consequence of):  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
|  | c. Due to (or as a consequence of):  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
|  | d. Due to (or as a consequence of):  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
|  |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>found 4/19/97</b>   |                                | 28b. Time of Injury<br><b>found 8:10 P M</b>   |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
|  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                | 28d. Describe how injury occurred<br><b>Unknown</b>  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Found: Outside</b>  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1900 Block Guilford Ave. Baltimore, Maryland</b>   |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>APRIL 20, 1997</b>   |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARY SAUNDERS KOSOWSKI 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |  | 32. Registrar's Signature<br>  |                                |  |  |   |   |  |   |                                     |  |                                     |  |                                     |  |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


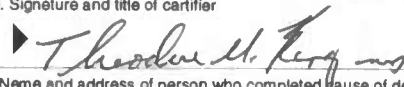

State of Maryland / Department of Health and Mental Hygiene

97 12620

Items 23 Part I, 27 5-29-97 Film G747 W.H. OCME

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARGARET WILLIAMS</b>  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 22 1997</b>  |  | 3. Time of Death<br><b>2:50 PM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>NA</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-70-2642</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                   | 7. Age (In yrs. last birthday)<br><b>39</b>   | If Under 1 Year<br>Months Days                               | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>12-23-57</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |  |  |
|   | 10a. State<br><b>Md</b>   | 10b. County<br><b>NA</b>   | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>5928 St. Regis Road</b>  |  | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>NA</b>     |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nursing Teacher</b>   |  | 16b. Kind of Business/Industry<br><b>Facilities</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Moye</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Wooten</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shanda Goods</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21206 5928 St. Regis Road Baltimore, Maryland</b>    |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Mem. Pk. Cem</b>   |  | 20c. Location - City or Town, State<br><b>04-28-97 Arbutus, MD.</b>  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue</b>  |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Myocardial Fibrosis</b>         |  |   |  | Approximate Interval Between Onset and Death   |
|   | a. Due to (or as a consequence of):   |  |   |  |  |
|   | b. Due to (or as a consequence of):   |  |   |  |  |
|   | c. Due to (or as a consequence of):   |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input checked="" type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>                              |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                     |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 23, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KARP 111 Penn Street, Baltimore, Maryland 21201</b>  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>   |   | 32. Registrar's Signature<br> |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12621

ITEMS: 23 PART I,II PER MEO G-747 5/17/97 reb Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |  |
|--|---|--|---|--|--|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>JOANN WIGGINS</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 24 1997</b>   |  | 3. Time of Death<br><b>4:50P.M.</b>                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>4 WILLARD STREET</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>n/a</b>                                       |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>212-58-7229</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>44</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 1, 1953</b>             |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |  |  |  |   |  |
| <b>To Be Completed by Funeral Director</b>   | Usual Residence of Decedent   |  |   |  |  |  |   |  |
|  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  | 10e. Street and Number<br><b>4 S. Willard St.</b>   |  |   |  | 10f. Zip Code<br><b>21223</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year of Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Writer</b>   |  | 16b. Kind of Business/Industry<br><b>Self Employed</b>                  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joe Willie Hargrove</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Jenkins</b>  |  |   |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Lucretia McClary/sister</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7210 Jimrowe Ct. Baltimore, MD 21237</b>   |  |   |  |
|  | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>  |  | Date<br><b>4/29</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>             |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>James A. Morton &amp; Sons Funeral Home<br/>1701 Laurens St. Balto., MD 21217</b>   |  |   |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |  |   |  |  |  |   |  |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>INTRACEREBRAL HEMORRHAGE</b></p> <p>Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div> |   |  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC NARCOTICISM</b>   |   |  |   |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |  |   |  |  |  |   |  |
| 24e. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |   |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>        |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |  |  | 28d. Describe how injury occurred  |   |  |
|  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)           |   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>   |   |  |   | 29c. License number<br><b>O.C.M.E.</b> |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 25, 1997</b>                         |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1997</b>  |   |  |   |  |  |  |   |  |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12622

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN GUY ARRINGTON

2. Date of Death

Month Day Year  
APR 3, 1997

3. Time of Death

5:45 AM

4a. Facility Name (If not institution, give street and number)

NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY CO.

Funeral  
Director

5. Social Security Number

577-03-8602

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JAN. 14, 1909

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY CO.

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1235-POTOMAC VALLEY

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

DIRECTOR &amp; COMMISSIONER

16b. Kind of Business/Industry

F.H.A.

17. Father's Name (First, Middle, Last)

JOHN THOMAS ARRINGTON

18. Mother's Name (First, Middle, Maiden Surname)

Unk. MUNGER

19a. Informant's Name/Relationship (Type, Print)

IONA B. ARRINGTON-WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15101-INTERLACHEN DR., #124, SILVER SPR. MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MONOCACY CEMETERY

Data

4/7

20c. Location - City or Town, State

BEALLSVILLE, MD.

21. Signature of Funeral Service Licensee

W.M. Hyson

22. Name and Address of Facility

HYSONG CO., INC.

1300- N ST., NW, WASH., DC 20005

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Myocardial Infarction

Approximate Interval Between Onset and Death

minutes

Due to (or as a consequence of):

b.

Arteriosclerosis

years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel J. Salter

29c. License number

033138

29d. Date signed (Month, Day, Year)

April 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel J. Salter MD 12850 middle brook Rd. Germantown, MD

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

John H. R. R. R.

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12623

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FEROZ AHMED

2. Date of Death

Month Day Year  
4-5-97

3. Time of Death

3:37pm

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

576-52-3033

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
8-5-40

9. Birthplace (State or Foreign Country)

Pakistan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

SILVER SPRINGS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

21 JAYSTONE CT.

10f. Zip Code

20905

10g. Citizen of What Country?

Pakistan

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PROFESSOR OF Social Science

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

QASIM HAJI

18. Mother's Name (First, Middle, Maiden Surname)

ZAINAB BEGUM

19a. Informant's Name/Relationship (Type, Print)

NADERA AHMED - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 Jaystone Ct, Silver Spring, Md. 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington

Date

4-7-97

20c. Location - City or Town, State

Adelphi, Md.

21. Signature of Funeral Service Licensee

Dane de Moten

22. Name and Address of Facility

Universal Mortuary Inc.  
411 Kennedy St., N.W., Wash., D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular Fibrillation

Due to (or as a consequence of):

b. Hypertrophic Cardiomyopathy

Due to (or as a consequence of):

c. Hypertensive Heart Disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 hour 17 min

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status Post Permanent Pacemaker

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

April 5, 1997

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Riaz Haider MD

29c. License number

DC 6835

29d. Date signed (Month, Day, Year)

April 5, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

RIAZ HAIDER, MD SUITE 102, 1140 VARNUM ST., NE, WASHINGTON, DC 20017

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

Julia Davidson-Robert

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12624

Items: 10a, b, c, e, f per executor, G-753 11/17/97 dh

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Iva C. Andrews

2. Date of Death

April 06, 1997

3. Time of Death

7:08 p.m.

4a. Facility Name (If not Institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Fort Washington Prince George's

4c. County of Death

Funeral  
Director

5. Social Security Number

577-40-7562

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 1, 1910

9. Birthplace (State or Foreign Country)

Dinwiddie, VA

Usual Residence of Decedent

10a. State  
Florida  
Maryland10b. County  
St. Lucie  
Prince George's

10c. City, Town, or Location

Fort Pierce  
Ft. Washington

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

14338 Amapola Circle  
805 Braeburn Drive

10f. Zip Code

34951  
20744

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Vocational Rehab. Specialist

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Amos Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Nora Bland

19a. Informant's Name/Relationship (Type, Print)

Nora Carmichael - Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

805 Braeburn Drive, Ft. Washington, MD 20744

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lee's Crematory

Date

4/12/97

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N. E., Washington, D. C.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Ventricular Arrhythmia  
Due to (or as a consequence of):b. Aortic MI  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1d.

1d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ch. cholestasis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Sidarous

29c. License number

D45365

29d. Date signed (Month, Day, Year)

4-7-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Sidarous, M.D., 11701 Livingston Road, Suite 101, Ft. Washington, MD. 20744

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

John A. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12625

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nellie V. Angle

2. Date of Death

April 13, 1997

3. Time of Death

18:00

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

215-44-9679

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jun 4 1904

9. Birthplace (State or Foreign Country)

Franklin Co., Pa.

Usual Residence of Decedent

10a. State

PA

10b. County

FRANKLIN

10c. City, Town or Location

MERCERSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7977 ROYER RD

10f. Zip Code

17236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John M. Shinham

18. Mother's Name (First, Middle, Maiden Surname)

Cora E. Winger

19a. Informant's Name/Relationship (Type, Print)

Kenneth R Angle, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8137 Royer Rd Mercersburg Pa 17236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Brethren Church Cemetery

Date

4/16

20c. Location - City or Town, State

Welsh Run Pa

21. Signature of Funeral Service Licensee

James J. Bowersox

22. Name and Address of Facility

Minnich Miller Mzy FH  
521 S Washington St Greensboro Pa.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multiple arterial emboli

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):  
Left atrial thromboses

weeks

Due to (or as a consequence of):  
atrial fibrillation

months

Due to (or as a consequence of):  
arteriosclerotic heart disease

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles C. Spencer M.D.

29c. License number

D11133

29d. Date signed (Month, Day, Year)

Apr 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles C. Spencer 11110 Medical Campus Rd Hagerstown MD

31. Date filed (Month, Day, Year)

APR 15 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





97 12626

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |  |   |   |  |  |
|--|--|---|---|---|--|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DAVID VLADIMIR ANTALEC   |  |   |   | 2. DATE OF DEATH<br>MONTH April DAY 15, YEAR 1997   |  |  |   | 3. TIME OF DEATH<br>4:35A   |  |  |
| 4. SOCIAL SECURITY NUMBER<br>283-38-9960   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br>54 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>December 11, 1942                          |   | 8. BIRTHPLACE (State or Foreign Country)<br>Tennessee   |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>21821 O'Toole Drive  |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  |  | 9c. COUNTY OF DEATH<br>Washington   |   |  |  |
| RESIDENCE OF DECEDENT  |  |   |   |   |  |  |   |   |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Washington   |   | 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |  |  |
| 10e. STREET AND NUMBER<br>21821 O'Toole Drive  |  |   |   | 10f. ZIP CODE<br>21742  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>9-1-1961-9-1-1984  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |   |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>4 years   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>1st. Sgt. U.S. Army  |   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Military                 |  |   |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Vladimir Samuel Antalec   |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Victoria Hoffman   |  |  |   |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>JoKay Snow   |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4307 B Quarters, Quantico, Virginia 21134  |  |  |   |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arlington National Cemetery 4-21-1997  |   |   | 20c. LOCATION — City or Town, State<br>Arlington, Virginia |  |   |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Douglas A. Fiery</i>   |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br>Douglas A. Fiery Funeral Home<br>1331 Eastern Blvd. North Hagerstown, Md.   |  |  |   |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Colon Cancer</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |   |   |  |  |   | Approximate Interval Between Onset and Death<br><i>1 year</i>   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |   |   |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |   |   |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |   |  |  |   |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Michael J. McCormack M.D.</i>  |  |   |   | 29c. LICENSE NUMBER<br>041667   |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4.18.97  |   |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Michael J. McCormack 11110 Medical Campus Suite 130 Hagerstown, MD 21742</i>   |  |   |   |   |  |  |   |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 21 1997   |  |   |   | 32. REGISTRAR'S SIGNATURE<br><i>Julia Anderson-Randall</i>  |  |  |   |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12627

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MELVIN E. ALDRIDGE, SR.

2. Date of Death

Month Day Year  
April 9, 1997

3. Time of Death

11 AM

4a. Facility Name (If not institution, give street and number)

4734 Skeet Club Road

4b. City, Town, or Location of Death

Hurlock

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

220-12-1375

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
02/20/25

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Hurlock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4734 Skeet Club Road

10f. Zip Code

21643

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
3

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Construction Worker

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Fred Aldridge

18. Mother's Name (First, Middle, Maiden Surname)

Myra Spry

19a. Informant's Name/Relationship (Type, Print)

Jerome Aldridge/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

503 Roslyn Ave., Cambridge, MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Petersburg Cemetery

Data

4-12

20c. Location - City or Town, State

Hurlock, Maryland

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home  
PO Box 43, Federalsburg, MD 2163223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sudden Aortic Thymia

Due to (or as a consequence of):

b. Coronary Ht disease (Presumed)

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 min

unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicida 4 ☐ Homicida

28a. Date of Injury

(Month, Day Year)

28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael F. Eskow

29c. License number

D26388

29d. Date signed (Month, Day, Year)

4-11-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael F. Eskow MD 302 Collins Hurlock MD 21643

31. Date filed (Month, Day, Year)

APR 14 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12628

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN G. ADDISON

2. Date of Death

Month April Day 07 Year 1997

3. Time of Death

4:45 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

215-46-0929

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Dec. Day 29 Year 1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16300 Layhill Road

10f. Zip Code

20905

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Store

17. Father's Name (First, Middle, Last)

Joseph B. Addison

18. Mother's Name (First, Middle, Maiden Surname)

Marjorie Ellison

19a. Informant's Name/Relationship (Type, Print)

Marjorie Walker (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1409 Robert Lewis Dr., Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ash Memorial Cem.

Date

4/14/97

20c. Location - City or Town, State

Sandy Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.

ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ESOPHAGEAL CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D25643

29d. Date signed (Month, Day, Year)

4/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12629

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Metta Lee Arnold

2. Date of Death

April 9, 1997

3. Time of Death

11:10 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

10210 Meredith Avenue

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

577-24-3690

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 31, 1921

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10210 Meredith Avenue

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thurman P. Baker

18. Mother's Name (First, Middle, Maiden Surname)

Olle Louise Hickys

19a. Informant's Name/Relationship (Type, Print)

Jack C. Arnold, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10210 Meredith Avenue, Silver Spring, Maryland 20910

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

4-10-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Carol A. Dalm

22. Name and Address of Facility

Rapp Funeral Services, P.A.  
933 Gist Avenue, Silver Spring, Maryland 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardio-respiratory Arrest

Approximate  
Interval Between  
Onset and Death

4 minutes

Due to (or as a consequence of):

b. Sepsis and Dehydration

5 days

Due to (or as a consequence of):

c. Cerebral Infarct

3 weeks

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

X

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Phillip W. Poth, M.D.

29c. License number

D 22117

29d. Date signed (Month, Day, Year)

April 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #32

Phillip W. Poth, M. D., 831 University Blvd., East, Silver Spring, MD 20903-2916

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12630

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD LESLIE ALLEN

2. Date of Death

Month Day Year  
APRIL 04 1997

3. Time of Death

2045

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

355-10-8351

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 13, 1915

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11722 Stonington Place

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

William J. Allen

18. Mother's Name (First, Middle, Maiden Surname)

Hannah Backe

19a. Informant's Name/Relationship (Type, Print)

Willena F. Allen

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11722 Stonington Place Silver Spring, Maryland 20902

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

4/08/97 Alexandria, Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. RESPIRATORY FAILURE

2 DAYS

Due to (or as a consequence of):

b. BRADY-ASYSTOLIC ARREST

2 DAYS

Due to (or as a consequence of):

c. SUBLUXATION OF CERVICAL SPINE

DAYS

Due to (or as a consequence of):

d. ANKYLOSING SPONDYLITIS

YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Vikramaditya Reddy MD

29c. License number

D43464

29d. Date signed (Month, Day, Year)

APRIL 04 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIKRANADITYA D. REDDY, 11125 ROCKVILLE PIKE, SUITE #303, ROCKVILLE, MD -20852

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12631

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |  |  |  |
|--|--|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Myung An</b>  |   |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>5</b> Year <b>1997</b> |  | 3. Time of Death<br><b>6:36 AM</b>       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>12602 Viers Mill Rd, #304</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Rockville</b>             |  | 4c. County of Death<br><b>Montgomery</b> |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-06-0768</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                                       | 8. Date of Birth (Month, Day, Year)<br><b>August 1, 1922</b>                                   |  | 9. Birthplace (State or Foreign Country)<br><b>Korea</b>   |
|  | Usual Residence of Decedent  |   |  |   |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Rockville</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>12602 Viers Mill Rd, #304</b>   |  |   |  | 10f. Zip Code<br><b>20853</b>   |  | 10g. Citizen of What Country?<br><b>Korea</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ahn Kyng San</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Chung Gan Ma</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph Young Seog Woo/Son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12602 Viers Mill Rd, #304, Rockville, MD 20853</b>  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woo Family Cemetery</b>  |  | Date<br><b>Apr 10</b>  |  | 20c. Location - City or Town, State<br><b>Young In, Korea</b>  |
| 21. Signature of Funeral Service Licensee<br><b>Alan J. Donnell</b>  |  |   |  | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home<br/>11800 New Hampshire Ave, Silver Spring, MD 20904</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute myocardial infarction.</b><br>Due to (or as a consequence of):<br>b. <b>Hypertension.</b><br>Due to (or as a consequence of):<br>c. <b>Diabetes mellitus.</b><br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br><b>Hee-Kwon H. Yoon MD</b>   |  | 29c. License number<br><b>D 14905</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/5/97</b>   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>HEE-KWON H. YOON 7307 BALTIMORE AVE. #111. COLLEGE PARK MD 20740</b>  |  |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 07 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randell</b>  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12632

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH L. ABBOTT

2. Date of Death

Month Day Year  
APRIL 6, 1997

3. Time of Death

9:26 AM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579 20 8561

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
FEB. 14, 1908

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

SANDY SPRING

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

17320 QUAKER LANE

10f. Zip Code

20860

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY CLERK

16b. Kind of Business/Industry

APPLIANCE COMPANY

17. Father's Name (First, Middle, Last)

JOHN RICHARD LeGATES

18. Mother's Name (First, Middle, Maiden Surname)

IDA LOUISE SCOTT

19a. Informant's Name/Relationship (Type, Print)

NANCY A. LAYFIELD, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3207 BENNETT POINT ROAD, QUEENSTOWN, MD. 21658

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. CARMEL CEMETERY

Date

4/9/97

20c. Location - City or Town, State

SUNSHINE, MD.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

MURIEL H. BARBER FUNERAL HOME  
P.O. BOX 5038, LAYTONSVILLE, MD. 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR FIBRILLATION

Approximate Interval Between Onset and Death

TERMINAL

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CONGESTIVE CARDIOMYOPATHY

3 YRS

c. Due to (or as a consequence of):

d. ARTERIOSELEROTIC C.U.D.

YRS.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GASTROINTESTINAL BLEEDING

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald R. Lewis

29c. License number

D06460

29d. Date signed (Month, Day, Year)

APRIL 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD R. LEWIS MD

RT 108 OLNEY, MD 20832

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

Lisa Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

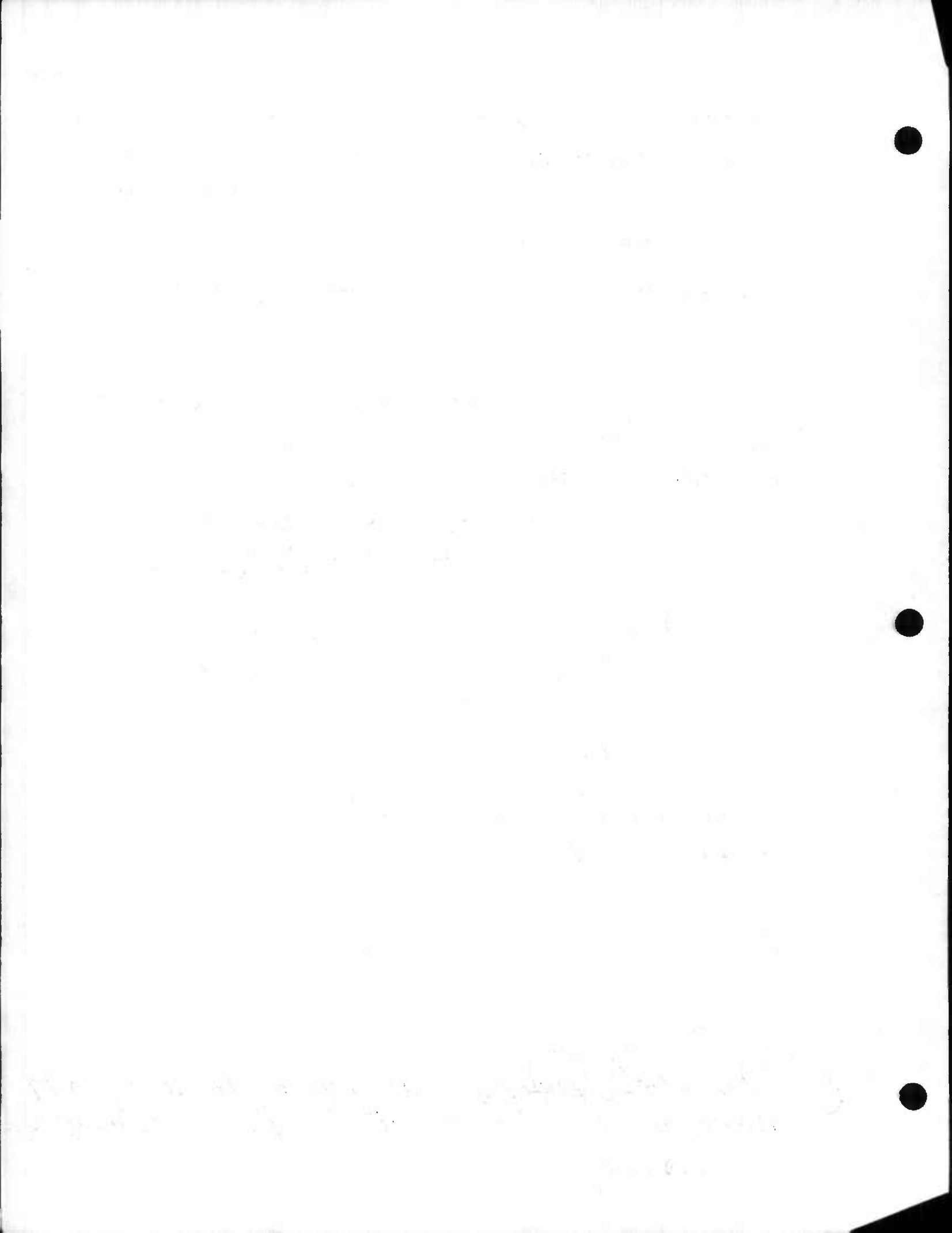
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12633

AMENDED #18, 4/17/97 LMG

Certificate of Death TALBOT Reg. No.

|  |  |   |   |  |                                      |
|--|--|---|---|--|--------------------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Elmer EDWARD Andrews</b>                                |   | 2. Date of Death<br>Month <b>April</b> Day <b>15</b> Year <b>1997</b> |  | 3. Time of Death<br><b>1:30 AM</b>   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Genesis ElderCare - The Pines</b> |   | 4b. City, Town, or Location of Death<br><b>Easton</b>                 |  | 4c. County of Death<br><b>Talbot</b> |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-03-7323</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.                      | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.       |
|  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 7, 1914</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>           |  |                                      |
| Usual Residence of Decedent  |  |   |   |  |                                      |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>TALBOT</b>  |   | 10c. City, Town or Location<br><b>EASTON</b>   |                                      |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |                                      |
| 10e. Street and Number<br><b>8825 BLACK DOG ALLEY</b>  |  | 10f. Zip Code<br><b>21601</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |                                      |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                      |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |   |  |                                      |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MECHANIC</b>  |   | 16b. Kind of Business/Industry<br><b>AUTOMOBILE</b>  |                                      |
| 17. Father's Name (First, Middle, Last)<br><b>HERMAN HENRY ANDREWS</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DOROTHY MAE MOORE FANNIE TRICE</b>  |   |  |                                      |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT E. ANDREWS/SON</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10708 CHAPEL ROAD, CORDOVA, MD 21625</b>  |   |  |                                      |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SPRING HILL CEMETERY</b>   |   | 20c. Location - City or Town, State<br><b>4-22 EASTON, MD</b>  |                                      |
| 21. Signature of Funeral Service Licensee<br><b>JOHN R. MERCER</b>   |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD 21601</b>  |   |  |                                      |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b><br><br>23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |   |  |                                      |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |                                      |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |                                      |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                      |
| 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |                                      |
| 29b. Signature and title of certifier<br><b>WJH</b>  |  | 29c. License number<br><b>D26350</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/15/97</b>  |                                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>WILLIAM BREMER, MD 800 S. TALBOT STREET ST. MICHAELS, MD 21663</b>  |  |   |   |  |                                      |
| 31. Date filed (Month, Day, Year)<br><b>APR 17 1997</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |                                      |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

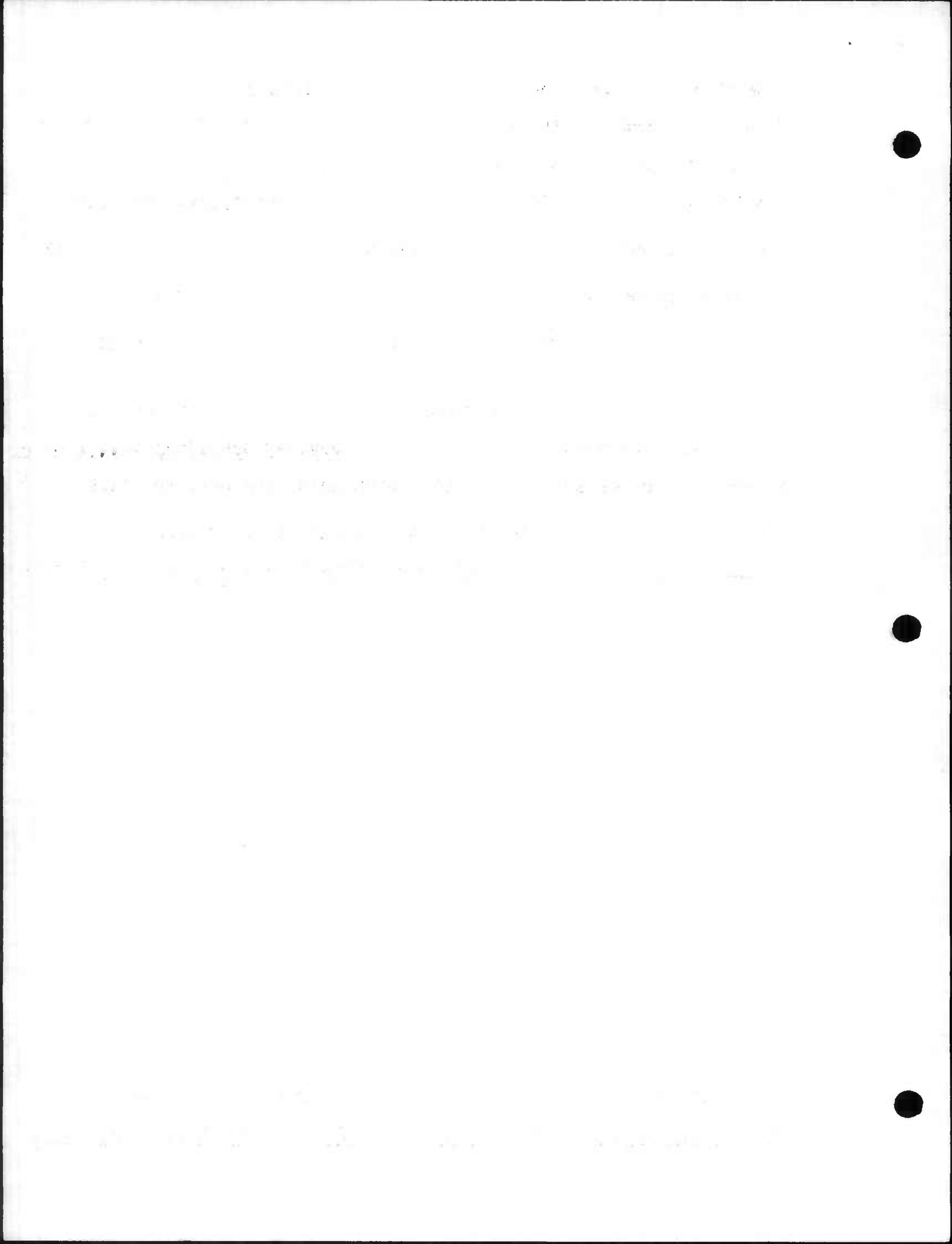
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Amended # 3, 4/14/97  
Rd, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12634

Certificate of Death

Reg. No.

|  |   |   |   |   |  |   |  |  |  |
|--|---|---|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Edgar Shaw Andrews Sr.  |   |   | 2. Date of Death<br>Month Day Year<br>April 11, 1997  |  | 3. Time of Death<br>5:00 A.M.   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>20605 Bethel Dr.S.W.  |   |   | 4b. City, Town, or Location of Death<br>Lonaconing  |  | 4c. County of Death<br>Allegany   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-10-4482  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>91 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>Oct. 10, 1905    | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent   |   |   |   |  |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  |   | 10b. County<br>Allegany   |   | 10c. City, Town or Location<br>Lonaconing  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br>4 Watercliff St.  |   |   |   | 10f. Zip Code<br>21539   |   | 10g. Citizen of What Country?<br>USA                       |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0   |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>B & O |  |   | 16b. Kind of Business/Industry<br>Railroad                 |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Wm. O. Andrews   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Katherine Shaw  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Frances Beeman  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16008 St. Marys Church Terr. S.W. Lonaconing, Md. 21539                                     |   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Frostburg Mem. Park  |   | 20c. Location - City or Town, State<br>Frostburg, Maryland |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Jas E. Manger  |   |   |   | 22. Name and Address of Facility<br>Eichhorn-McKenzie Funeral Home<br>Lonaconing, Md. 21539  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. metastatic disease to stomach<br>Due to (or as a consequence of):<br>b. carcinoma of bladder<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>1 yr<br>25 yrs |   |   |   |  |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>No<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Nature <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury<br>(Month, Day Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br>Donald F. Manger M.D.   |   |   |   | 29c. License number<br>D05231   |  | 29d. Date signed (Month, Day, Year)<br>April 11 1997  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Donald F. Manger 70 Main St., Lonaconing, Md. 21539  |   |   |   |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 14 1997   |   | 32. Registrar's Signature<br>John [Signature]   |   |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12635

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille

Bell

2. Date of Death

Month Day Year  
April 9, 1997

3. Time of Death

2:55 P.M.

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

244-40-9779

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
5/20/28

9. Birthplace (State or Foreign Country)

Concord, N.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

Yes ☒ No ☐

10e. Street and Number

5901 Fisher Rd. Apt. 103

10f. Zip Code

20748

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Food Service Worker

16b. Kind of Business/Industry

D.C. Public Schools

17. Father's Name (First, Middle, Last)

John Cureton

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Stradford

19e. Informant's Name/Relationship (Type, Print)

Mary Ann Murphy/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rock Hill Cemetery 4/16/97

Date

20c. Location - City or Town, State

Concord, N.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home  
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYO CARDIAL INFARCTION

ACUTE

Due to (or as a consequence of):

b. ATHEROSCLEROSIS

YEARS

Due to (or as a consequence of):

c. HYPERTENSION

YEARS

Due to (or as a consequence of):

d. DIABETES MELLITUS

YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prior exam

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician:2 ☐ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D25422

29d. Date signed (Month, Day, Year)

APRIL 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERT MALLIN MD 14333 LAUREL BOWIE RD, LAUREL, MD 20708

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12636

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Louise Barber

2. Date of Death

April 6 1997

Day

Year

3. Time of Death

9:00 AM

4a. Facility Name (If not Institution, give street and number)

12408 Keynote Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

578 32 3244

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 22, 1924

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12408 Keynote Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ray E. Frith

18. Mother's Name (First, Middle, Maiden Surname)

Helen Portch

19a. Informant's Name/Relationship (Type, Print)

Wilfred Allen Barber Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12414 Keynote Lane Bowie Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

April 9, 1997

20c. Location - City or Town, State

Brentwood Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

b. Severe Diabetes Mellitus

Due to (or as a consequence of):

c. End Stage Rheumatoid arthritis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20302

29d. Date signed (Month, Day, Year)

4/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert J. Gereige M.D. 4410 74th Ave Landover Hills Md 20784

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12637

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ADA ETHEL BALDWIN

2. Date of Death

Month Day Year  
APRIL 7, 1997

3. Time of Death

3:20 A.M.

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES' HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES'

Funeral  
Director

5. Social Security Number

577-30-3471

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

NOV. 5, 1905

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES'

10c. City, Town or Location

LANDOVER

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

505 PEACOCK DRIVE

10f. Zip Code

20785

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

DIETARY TECHNICIAN

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

LEWIS THOMPSON

18. Mother's Name (First, Middle, Maiden Surname)

ALICE BYRUM

19a. Informant's Name/Relationship (Type, Print)

IDA CURTIS, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

505 PEACOCK DRIVE, LANDOVER, MARYLAND 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

4/11/97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME, INC.

3401 BLADENSBURG RD., BRENTWOOD, MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia  
Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.   
Dua to (or as a consequence of):c.   
Dua to (or as a consequence of):d.   
Dua to (or as a consequence of):

Approximate Interval Between Onset and Death

Days.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia  
s/p CVA.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41978

29d. Date signed (Month, Day, Year)

4-7-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. J. Koli

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

John A. Randall

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12638

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucy Virginia Boynton

2. Date of Death

Month Day Year  
April 4, 1997

3. Time of Death

7:45 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Magnolia Gardens Nursing Home

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

579-10-9333

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 29, 1919

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7235 Morrison Drive

10f. Zip Code

20770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Ralph Otto Flickinger

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Augusta Montgomery

19a. Informant's Name/Relationship (Type, Print)

Mary M. Potter - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7235 Morrison Drive, Greenbelt, Maryland 20770

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

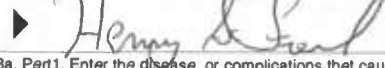
Date

4/5/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Asystole

Due to (or as a consequence of):

20 Minutes

b. Metastatic Adenocarcinoma Esophagus

Due to (or as a consequence of):

8 Months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. with Cerebral Metastasis

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Degenerative joint disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 M.D.

29c. License number

D22549

29d. Date signed (Month, Day, Year)

April 4, 1997

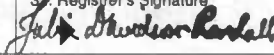
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

G.M. Din, M.D. 6510 Kenilworth Avenue, Riverdale, Maryland 20737

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-d show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

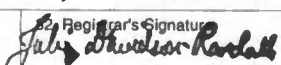
State of Maryland / Department of Health and Mental Hygiene

97 12639

## Certificate of Death

Reg. No.

Amended #3 9/18 PGC. 4/19/97 E.H.M.

|  |  |   |   |   |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
|--|--|---|---|---|--|---------------------------------|--------------------------------|--|--|--|--|---|---|---------------------------------------|---|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Henry Bryan</b>  |   |   |   | 2. Date of Death<br>Month <b>April</b> Day <b>2</b> Year <b>1997</b>   |                                 |                                |  | 3. Time of Death<br><b>9:00 P.M.</b>   |  |  |   |   |                                       |   |                                   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>7103 Rhode Island Avenue</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>College Park</b>  |                                 |                                |  | 4c. County of Death<br><b>Prince George's</b>  |  |  |   |   |                                       |   |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-16-4063</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |                                 | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>August 26, 1921</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b> |                                       |   |                                   |  |
|  | Usual Residence of Decedent  |   |   |   |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince George's</b>   |   | 10c. City, Town or Location<br><b>College Park</b>   |                                 |                                |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |   |                                       |   |                                   |  |
|  | 10e. Street and Number<br><b>7103 Rhode Island Avenue</b>  |   |   |   | 10f. Zip Code<br><b>20740</b>  |                                 |                                |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |   |   |                                       |   |                                   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |   |   |                                       |   |                                   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10 years</b> College (14 or 5+) <b>College</b>  |   |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Foreman</b>   |                                 |                                |  | 16b. Kind of Business/Industry<br><b>Washington Suburban Sanitary Commission</b>               |  |  |   |   |                                       |   |                                   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Henry P. Bryan</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><del>Joan Audrey Parker</del> <b>Sadie Pront</b>  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert A. Bryan /Son</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6100 Westchester Park Drive, College Park, Md. 20740</b>                                 |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>   |                                 |                                |  | Date<br><b>4/7/1997</b>  |  | 20c. Location - City or Town, State<br><b>Brentwood, Md.</b>     |   |   |                                       |   |                                   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |   | 22. Name and Address of Facility<br><b>4739 Baltimore Ave., Hyattsville, Md. 20781</b>   |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Acute Myocardial Infarction</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>Sudden</b></td> </tr> <tr> <td>b. <b>Coronary Artery Disease</b></td> </tr> <tr> <td>c. <b>Due to (or as a consequence of):</b></td> </tr> <tr> <td>d. <b>Due to (or as a consequence of):</b></td> </tr> </table> |   |   |   |  |                                 |                                |  |  |  |  |   | Immediate Cause (Final disease or condition resulting in death)     | a. <b>Acute Myocardial Infarction</b> | Approximate Interval Between Onset and Death<br><b>Sudden</b> | b. <b>Coronary Artery Disease</b> | c. <b>Due to (or as a consequence of):</b> |
| Immediate Cause (Final disease or condition resulting in death)  | a. <b>Acute Myocardial Infarction</b>  | Approximate Interval Between Onset and Death<br><b>Sudden</b> |   |   |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
|  | b. <b>Coronary Artery Disease</b>  |   |   |   |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
|  | c. <b>Due to (or as a consequence of):</b>   |   |   |   |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
|  | d. <b>Due to (or as a consequence of):</b>   |   |   |   |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Lung Disease</b><br><b>Parkinson's Disease</b>  |  |   |   |   |  |                                 |                                |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |   |                                       |   |                                   |  |
|  |  |   |   |   |  |                                 |                                |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |                                       |   |                                   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b> |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |   |                                       |   |                                   |  |
|  |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                 |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |  |  |   |   |                                       |   |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
| 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br><b>014799</b>  |  |                                 |                                | 29d. Date signed (Month, Day, Year)<br><b>April 4, 1997</b>                      |  |  |  |   |   |                                       |   |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>K. Joseph Mathew, M.D., 6510 Kenilworth Avenue, Suite 1400, Riverdale, Md. 20737</b>  |  |   |   |   |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 07 1997</b>  |  |   |   |   |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |
| 32. Registrar's Signature<br>   |  |   |   |   |  |                                 |                                |  |  |  |  |   |   |                                       |   |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12640

Certificate of Death

Reg. No.

|  |   |   |   |  |   |  |  |   |
|--|---|---|---|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Henry Brautigam</b>  |   |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>3</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>9:00 PM</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Crofton Convalescent Center</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Crofton</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>220 26 6677</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 24 1912</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Russia</b> |
|  | Usual Residence of Decedent   |   |   |  |   |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Bowie</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>12116 Foxhill Lane</b>   |   |   |  | 10f. Zip Code<br><b>20715</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Banker</b>                        |  | 16b. Kind of Business/Industry<br><b>Banking</b>  |  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>George Brautigam</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katherine Brungardt</b>   |  |  |   |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lauretta B. Brautigam</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12116 Foxhill Lane Bowie Maryland 20715</b>   |  |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakemont Memorial Gardens</b>  |  | 20c. Date<br><b>April 7, 1997</b>   |  | 20d. Location - City or Town, State<br><b>Davidsonville Md.</b>                                |   |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.<br/>16000 Annapolis Rd. Bowie Md. 20715</b>   |  |  |   |
|  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br><b>b. pneumonia.</b><br>Due to (or as a consequence of):<br><b>c. STROKE</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |   |  |  |   |
|  | 23b. Approximate Interval Between Onset and Death<br><b>&gt; 2-days</b><br><b>&gt; 3-days</b><br><b>&gt; one year</b>   |   |   |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|  |   |   |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |   | 28d. Describe how injury occurred   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |   |  |  |   |
| 29b. Signature and title of certifier<br><b>S. J. Rao, MD.</b>   |   |   |   | 29c. License number<br><b>D-34525</b>            |   | 29d. Date signed (Month, Day, Year)<br><b>04-04-97</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>4000-Mitchellville Road; #220; Bowie-MD-20716.</b>  |   |   |   |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1997</b>  |   | 32. Registrar's Signature<br>  |   |  |   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

8

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12641

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |                          |  |   |  |  |  |
|---|---|---|--|--|---|--------------------------|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MARY BRANSON                            |   |  |  | 2. Date of Death<br>Month Day Year<br>APRIL 6, 1997 |                          |  |   | 3. Time of Death<br>7:12pm   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>SUBURBAN HOSPITAL |   |  |  | 4b. City, Town, or Location of Death<br>BETHESDA    |                          |  |   | 4c. County of Death<br>MONTGOMERY  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>UNKNOWN  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>84 Yrs.           |                          | 8. Date of Birth (Month, Day, Year)<br>Mar. 22, 1913 |   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |  |
|   | Usual Residence of Decedent   |   |  |  | 10c. City, Town or Location<br>WASHINGTON, D.C.     |                          |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 10a. State  |   | 10b. County   |  | 10e. Street and Number<br>2217 Kearney St. N.E.  |   |                          |  | 10f. Zip Code<br>20018  |  | 10g. Citizen of What Country?<br>U.S.A.        |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   |                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5th<br>College (14 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Domestic Engineer   |   |                          |  | 16b. Kind of Business/Industry<br>Private   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Richard Stevenson  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ella Blake  |   |                          |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Deborah Richardson/Granddaughter  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4623 Burlington Rd, Hyattsville Md. 20781   |   |                          |  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Olivet Cemetery 4/12/97  |   |                          |  | 20c. Location - City or Town, State<br>Washington, D.C.   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Belva J. Jenkins   |   |   |  | 22. Name and Address of Facility<br>Johnson & Jenkins Inc.<br>716 Kennedy St., N.W. Wash. D.C. 20011   |   |                          |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Sepsis<br>Due to (or as a consequence of):<br>b. Pneumonia<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  | Approximate Interval Between Onset and Death<br>Days<br>Days   |   |                          |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Demented  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |                          |  |   |  |  |  |
|   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                          |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |                          |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |   |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred              |  |
|   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>and manner stated.   |   |   |  | 29b. Signature and title of certifier<br>17.0  |   |                          |  | 29c. License number<br>D20516   |  | 29d. Date signed (Month, Day, Year)<br>4/12/97 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Tom Schulman 9410 Old Georgetown Rd Bethesda, MD 20814  |   |   |  | 31. Date filed (Month, Day, Year)<br>APR 10 1997   |   |                          |  | 32. Registrar's Signature<br>John Anderson-Rodell   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended # 8 Y.S.G. 4/11/97

State of Maryland / Department of Health and Mental Hygiene

97 12642

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |                                |  |   |
|--|--|--|---|--|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Helen P. Bajrak</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 8, 1997</b>   |                                | 3. Time of Death<br><b>7:50PM</b>  |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>3712 COOPERS LANE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>HYATTSVILLE</b>   |                                | 4c. County of Death<br><b>PRINCE GEORGES'</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-01-1493</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 23, 1917</b>  | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, DC</b> |
|  | Usual Residence of Decedent  |  |   |  |  |                                |  |   |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>PRINCE GEORGES'</b>   |  | 10c. City, Town or Location<br><b>HYATTSVILLE</b>  |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>3712 COOPERS LANE</b>   |  |   |  | 10f. Zip Code<br><b>20784</b>  |                                | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                            |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> Collega (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TELEPHONE OPERATOR</b>  |  | 16b. Kind of Business/Industry<br><b>COMMUNICATIONS</b>  |                                |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>IVAN MIKALASKI</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DOROTHY ERDMANN</b>  |                                |  |   |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>HUSSEIN BAJRAK, HUSBAND</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3712 COOPERS LANE, HYATTSVILLE, MARYLAND 20784</b>   |                                |  |   |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FORT LINCOLN CREMATORY</b>   |  | Date<br><b>4/10/97</b>   |                                | 20c. Location - City or Town, State<br><b>BRENTWOOD, MARYLAND</b>                                  |   |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>FORT LINCOLN FUNERAL HOME, INC.<br/>3401 BLADENSBURG RD., BRENTWOOD, MD 20722</b>   |                                |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CARDIAC ARREST</b><br>Due to (or as a consequence of):<br><b>b. HYPERTENSION</b><br>Due to (or as a consequence of):<br><b>c. MITRAL VALVE PROLAPSE</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |                                |  |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |                                |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RENAL DYSFUNCTION - STONES</b><br><b>HYPERPARATHYROIDISM</b><br><b>STROKE</b>   |  |   |  |  |                                |  |   |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury et Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how Injury occurred  |                                |  |   |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                |  |   |
| State<br>Registrar   | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D20302</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>APRIL 10, 1997</b>                                       |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT J. GEREIGE, M.D., 4410 74TH AVENUE, LANDOVER, MARYLAND 20784</b>   |  |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 10 1997</b>              |  |  |   | 32. Registrar's Signature<br> |  |                                |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 97 12643  
Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALBERT TIMOTHY BAKER</b>                                   |  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>12</b> Year <b>1997</b> |  | 3. Time of Death<br><b>1020a</b>                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>35105 MT. HERMON ROAD (in ditch)</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>POWELLVILLE</b>            |  | 4c. County of Death<br><b>WICOMICO</b>                |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-22-7733</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><b>8/15/27</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Wicomico</b>  |  | 10c. City, Town or Location<br><b>Powellville</b>     |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>35105 Mt. Hermon RD</b>   |  | 10f. Zip Code<br><b>21852</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bottler</b>  |  | 16b. Kind of Business/Industry<br><b>Soft Drink Manufacturer</b>   |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Horace Cleveland Baker</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Fannie Martha Rayne</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Martha Ann Simpson/Daughter</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7446 W. Adkins Ave. Willards, MD 21874</b>   |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pittsville Cemetery</b>   |  | Date<br><b>4/15/97</b>   |   | 20c. Location - City or Town, State<br><b>Pittsville, MD</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   | 22. Name and Address of Facility<br><b>Burbage Funeral Home<br/>108 William St. Berlin, MD 21811</b>   |  |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Atherosclerotic Cardiovascular disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |  |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|   |   |  |  |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
|   |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how Injury occurred  |   |  |   |  |
|   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  |  | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 13, 1997</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>  |   |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12644

## Certificate of Death

Reg. No.

|  |   |  |   |   |   |   |   |   |  |
|--|---|--|---|---|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CARRIE SMITH BRITTINGHAM</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 6, 1997</b>  |   | 3. Time of Death<br><b>5:39 PM</b>                                      |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>U.S.#13 &amp; WINTER QUARTER DRIVE</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>POCOMOKE</b>   |   | 4c. County of Death<br><b>WORCESTER</b>                                 |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-05-2073</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.            | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 18, 1912</b>             | 9. Birthplace (State or Foreign Country)<br><b>Jenkins Bridge Va</b>  |  |
|  | Usual Residence of Decedent   |  |   |   |   |   |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Worcester</b>   |   | 10c. City, Town or Location<br><b>Pocomoke</b>  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  | 10e. Street and Number<br><b>1402 Linden Drive</b>  |  |   |   | 10f. Zip Code<br><b>21851</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>                             |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress &amp; Homemaker</b>        |   | 16b. Kind of Business/Industry  |   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John S. Smith</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrie Mears</b>  |   |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>James S. Martin-Nephew</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 Front St., Pocomoke Md. 21851</b>  |   |   |   |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Salisbury Crematory</b>  |   | Date<br><b>4/7</b>  |   | 20c. Location - City or Town, State<br><b>Salisbury Md.</b>             |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Scott S. Melson</b>   |  |   |   | 22. Name and Address of Facility<br><b>Melson Funeral Home<br/>PO Box 64, Pocomoke Md. 21851</b>  |   |   |   |  |
|  | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Multiple Injuries</b><br>Due to (or as a consequence of):<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   |   |   |   |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |   |   |   |   |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |   |   |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |   |   |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |   |   |   |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>ROADWAY</b> |   |  |   |   |   |   |   |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                              |   | 28a. Date of Injury (Month, Day Year)<br><b>4/6/97</b>   |   | 28b. Time of Injury<br><b>1733 H.R.</b>                     |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred<br><b>Subject driven over by another vehicle</b>  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated above and manner stated.   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>roadway</b> |   |   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>intersection 4513 and winter quarter drive Pocomoke Maryland</b> |  |
| 29b. Signature and title of certifier<br><b>Theodore M. King</b>   |   |  |   | 29c. License number<br><b>O.C.M.E</b>                       |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 7, 1997</b>                                     |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>TITUS PORE M. King 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |   |   |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 11 1997</b>  |   |  |   | 32. Registrar's Signature<br><b>John A. Anderson-Rodell</b> |   |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Certificate of Death

97 12645

Reg. No.

|  |   |                                |   |  |  |  |  |  |
|--|---|--------------------------------|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>PEARL HUGHES BATCHELER  |                                |   |  | 2. Date of Death<br>Month Day Year<br>4 April 1997   |  | 3. Time of Death<br>4:40p.m.   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Homewood Retirement Center  |                                |   |  | 4b. City, Town, or Location of Death<br>Williamsport   |  | 4c. County of Death<br>Washington  |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-12-3138  |                                | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>74 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 1, 1922                                  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland  |                                | 10a. State<br>Maryland  |  | 10b. County<br>Washington  |  | 10c. City, Town or Location<br>Williamsport  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                | 10e. Street and Number<br>16505 Virginia Avenue   |  | 10f. Zip Code<br>21795   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0-12<br>College (14 or 5+) 1-4   |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>elementary teacher   |  | 16b. Kind of Business/Industry<br>public school system   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>George Lewis Pruett  |                                |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lola Pearl Hughes   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Linda Clerk/Daughter   |                                |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>118 West Magnolia Avenue, Hagerstown, Maryland 21742  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hagerstown Crematory  |  | 20c. Date<br>Apr. 12, 1997   |  | 20d. Location - City or Town, State<br>Hagerstown, Maryland                          |  |
|  | 21. Signature of Funeral Service Licensee<br>Scott Minnich  |                                | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 East Wilson Blvd., Hagerstown, Maryland 21740   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. PROTEIN-CALCIC MALNUTRITION<br>Due to (or as a consequence of):<br>b. CANCINOMATOSIS<br>Due to (or as a consequence of):<br>c. CANCINOMA OF BLADDER<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>3 WKS<br>1 MONTH<br>1 MONTH |                                |   |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                                |   |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |                                |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No          |   |                                |   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |                                | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                | 28d. Describe how injury occurred   |  |  |  |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |   |  |  |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |                                |   |  |  |  |  |  |
| 29b. Signature and Title of Certifier<br>The Honorable Medical Director  |   | 29c. License number<br>D 17067 |   | 29d. Date signed (Month, Day, Year)<br>4/12/97 |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>STEPHEN E. METZGER, MD 747 Northern Ave Hagerstown, Md 21742 |   |                                |   |  |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br>APR 15 1997  |                                |   |  | 32. Registrar's Signature<br>John Andrew Rickett   |  |  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





97 12646

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Walter M. Beard</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>April 12 1997</i>   |  | 3. TIME OF DEATH<br>HOURS MINUTES<br><i>1:41 P</i>   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>213-16-1873</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>86</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>May 1, 1910</i>   |  |   |  |  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Pennsylvania</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Washington County Hospital</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Hagerstown</i>   |  |   |  |  |  |
| 9c. COUNTY OF DEATH<br><i>Washington</i>   |  |  |  | 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Washington</i>   |  |   |  |  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Hagerstown</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>13709 Lois Street</i>   |  |   |  |  |  |
| 10f. ZIP CODE<br><i>21742</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |   |  |  |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>8 years</i>   |  |  |  |   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Laborer</i>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>General Construction</i>  |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>John H. Beard</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary Elizabeth Bouders</i>   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Goldie B. Beard</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>13709 Lois Street Hagerstown, Maryland 21742</i>   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Rest Haven Cemetery April 15, 1997 Hagerstown, Maryland</i>  |  |  |  |   |  |  |  |
| 20c. LOCATION — City or Town, State  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Douglas A. Fiery</i>   |  |  |  |   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><i>Douglas A. Fiery Funeral Home<br/>1331 Eastern Blvd. N. Hagerstown, Md. 21742</i>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>Cardiorespiratory arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Arteriosclerotic heart disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Generalized arteriosclerosis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>L. L. Packer Jr. MD</i>  |  |  |  |   |  |  |  |
| 29c. LICENSE NUMBER<br><i>009930</i>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>4/15/97</i>  |  |  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>L. L. Packer Jr. MD 145 W. Washington St., Hagerstown, MD</i>  |  |  |  |  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 17 1997</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12647

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
|---|---|---|---|---|--|---|--|--|--|--|---|----|------------------------------|---|----|---------------|----|--|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Mary Irene BAKER</i>   |   |   |   |  |   | 2. Date of Death<br>Month <i>April</i> Day <i>15</i> Year <i>1997</i>          |  | 3. Time of Death<br><i>1620</i>  |  |   |    |                              |   |    |               |    |  |    |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Washington County Hospital</i>   |   |   |   |  |   | 4b. City, Town, or Location of Death<br><i>Hagerstown</i>                      |  | 4c. County of Death<br><i>Washington</i>   |  |   |    |                              |   |    |               |    |  |    |
| Funeral<br>Director   | 5. Social Security Number<br><i>213-80-3617</i>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><i>40</i> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><i>Dec. 3, 1956</i>                     |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>                                    |  |   |    |                              |   |    |               |    |  |    |
|   | Usual Residence of Decedent   |   |   |   |  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
| To Be Completed by Funeral Director   | 10a. State<br><i>Maryland</i>   |   | 10b. County<br><i>Washington</i>  |   | 10c. City, Town or Location<br><i>Hagerstown</i>   |   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |    |                              |   |    |               |    |  |    |
|   | 10e. Street and Number<br><i>1912 Day Road</i>  |   |   |   | 10f. Zip Code<br><i>21740</i>  |   | 10g. Citizen of What Country?<br><i>USA</i>                                    |  |  |  |   |    |                              |   |    |               |    |  |    |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>white</i>  |  |  |   |    |                              |   |    |               |    |  |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>9</i> College (1-4 or 5+) <i>0</i>  |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>homemaker</i>                     |   |  |   | 16b. Kind of Business/Industry<br><i>her own home</i>                          |  |  |  |   |    |                              |   |    |               |    |  |    |
|   | 17. Father's Name (First, Middle, Last)<br><i>Leroy Hose</i>  |   |   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mary Jane O'Salley</i> |  |  |  |   |    |                              |   |    |               |    |  |    |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Donald W. Baker - husband</i>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1912 Day Road, Hagerstown, Maryland 21740</i>  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Cedar Lawn Mem. Park</i>   |   | Date<br><i>4-18-97</i>   |   | 20c. Location - City or Town, State<br><i>Hagerstown, Maryland</i>             |  |  |  |   |    |                              |   |    |               |    |  |    |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |   | 22. Name and Address of Facility<br><i>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>   |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
|   | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><i>Myocardial Infarction</i></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><i>2-5 Hrs.</i></td> </tr> <tr> <td>b.</td> <td><i>Asthma</i></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |   |   |  |   |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. | <i>Myocardial Infarction</i> | Approximate Interval Between Onset and Death<br><i>2-5 Hrs.</i> | b. | <i>Asthma</i> | c. |  | d. |
| Immediate Cause (Final disease or condition resulting in death)   | a.  | <i>Myocardial Infarction</i>  | Approximate Interval Between Onset and Death<br><i>2-5 Hrs.</i>   |   |  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
|   | b.  | <i>Asthma</i>   |   |   |  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
|   | c.  |   |   |   |  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
|   | d.  |   |   |   |  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Diabetes Mellitus (Insulin Dependent)</i>  |   |   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |   |    |                              |   |    |               |    |  |    |
|   |   |   |   |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |    |                              |   |    |               |    |  |    |
|   |   |   |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |    |                              |   |    |               |    |  |    |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |   |    |                              |   |    |               |    |  |    |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |  |  |   |    |                              |   |    |               |    |  |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
| 29b. Signature and title of certifier<br><i>[Signature] MD</i>  |   |   |   | 29c. License number<br><i>D46561<br/>BQ 4585052 (DEN)</i> |  | 29d. Date signed (Month, Day, Year)<br><i>April 15, 1997</i>                                |  |  |  |  |   |    |                              |   |    |               |    |  |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>GHAZALA QADIR MD. ROBINWOOD MEDICAL CENTER HAGERSTOWN MD</i>   |   |   |   |   |  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |
| 31. Date filed (Month, Day, Year)<br><i>APR 16 1997</i>   |   |   |   |   |  |   |  |  |  |  |   |    |                              |   |    |               |    |  |    |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12648

## Certificate of Death

Reg. No.

|                                     |   |  |   |                                |  |
|-------------------------------------|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Rachel Sachs Bailey   |  | 2. Date of Death<br>Month Day Year<br>April 10 1997   |                                | 3. Time of Death<br>10:55PM  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br>The Memorial Hospital   |  | 4b. City, Town, or Location of Death<br>Easton  |                                | 4c. County of Death<br>Talbot  |
| Funeral<br>Director                 | 5. Social Security Number<br>215-18-4646  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>74 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|                                     | 8. Date of Birth (Month, Day, Year)<br>Oct. 27, 1922  |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |                                |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent   |  | 10a. State<br>Maryland  |                                | 10b. County<br>Talbot  |
|                                     | 10c. City, Town or Location<br>Easton   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                                |  |
|                                     | 10e. Street and Number<br>107-S. West Street  |  | 10f. Zip Code<br>21601  |                                | 10g. Citizen of What Country?<br>U.S.  |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: Black  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4or 5+)   |                                | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Process Line-Helper  |
|                                     | 17. Father's Name (First, Middle, Last)<br>Charles Edward Bailey  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emma Bertha Brooks   |                                |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br>Joyce Jenkins (Daughter)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2110 Dover Bridge Road Preston, Maryland 21655   |                                |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Paradise Cemetery   |                                | 20c. Location - City or Town, State<br>4/16/97 Trappe, Maryland  |
|                                     | 21. Signature of Funeral Service Licensee<br>Shirley C. Henry   |  | 22. Name and Address of Facility<br>Henry Funeral Home<br>510 Washington St. Cambridge, Maryland 21613  |                                |  |
|                                     | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. congestive heart failure<br>Due to (or as a consequence of):<br>b. Atherosclerotic heart disease<br>Due to (or as a consequence of):<br>c. Hypertension<br>Due to (or as a consequence of):<br>d. End stage renal disease dialysis dependent |  | Approximate Interval Between Onset and Death<br>3 day<br>1 year<br>several years<br>3/9/94  |                                |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>severe peripheral vascular disease<br>anemia of chronic disease<br>adult onset diabetes mellitus  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |                                |  |
|                                     | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br>M   |
|                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>Syed I. Ali, M.D.  |                                |  |
|                                     | 29c. License number<br>D 46020  |  | 29d. Date signed (Month, Day, Year)<br>4/11/97  |                                |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Syed I. Ali, M.D. 506 Idlewild Avenue Easton, Md. 21601   |  | 31. Date filed (Month, Day, Year)<br>APR 14 1997  |                                |  |
|                                     | 31. Registrar's Signature<br>John A. Randolph   |  |   |                                |  |

Baltimore, Maryland 21215-0020

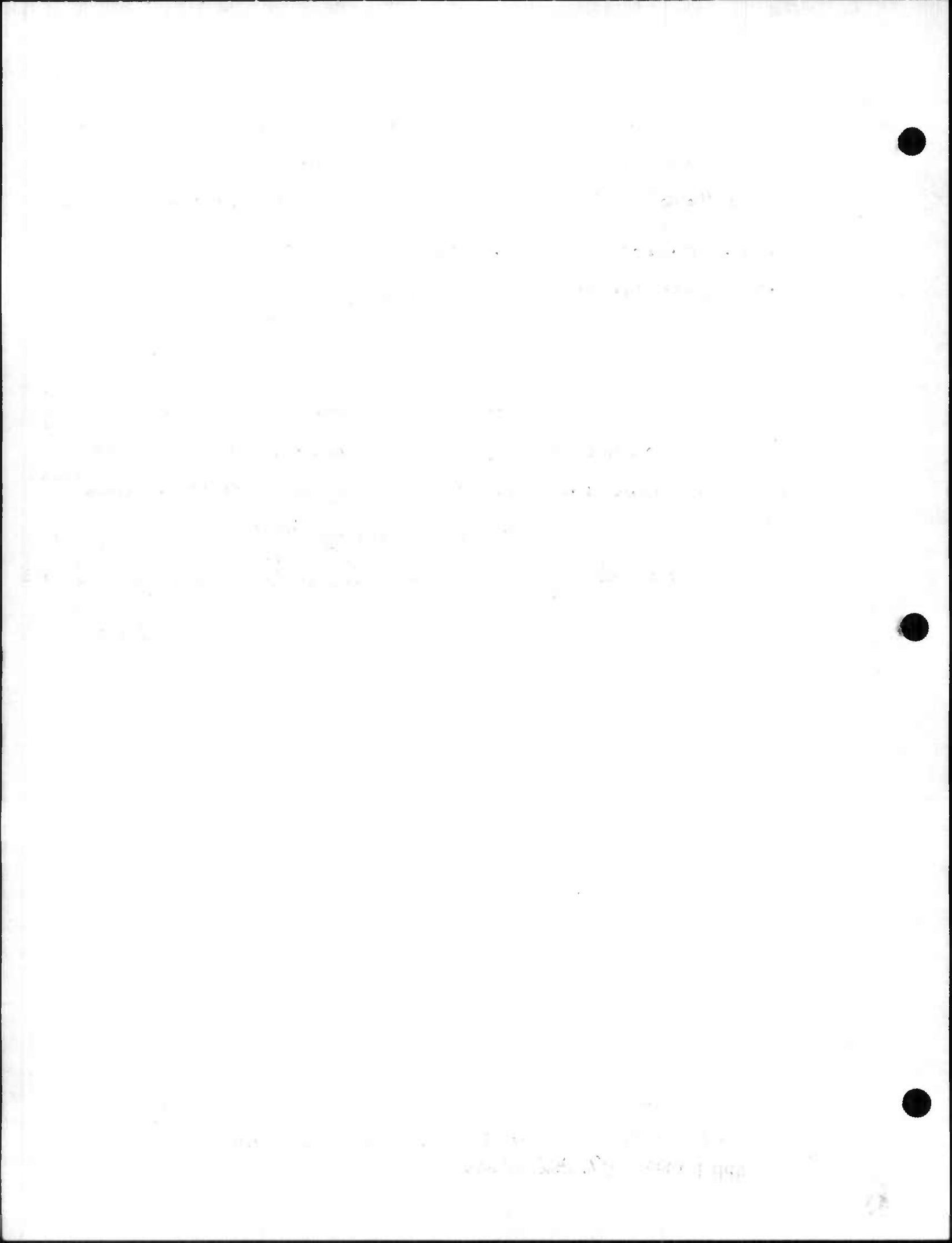
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12649

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM H. BROWN, JR.

2. Date of Death

APRIL 07 1997 0109 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-30-5536

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 14, 1915

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6218 Dunrobbin Drive

10f. Zip Code

20816

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Water Registrar

18b. Kind of Business/Industry

District of Columbia  
Government

17. Father's Name (First, Middle, Last)

William H. Brown, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ferry

19a. Informant's Name/Relationship (Type, Print)

Dorothy M. Brown/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6218 Dunrobbin Drive, Bethesda, Maryland 20816

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)April 10, 1997  
Parklawn Memorial Park

Date

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Barbara J. McMillan Lawrence

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Arrest

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 hour

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. CONSCIOUS HEART FAILURE

Due to (or as a consequence of):

24 hours

c. Acute Myocardial Infarction

Due to (or as a consequence of):

13 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Right Pneumonia

History of Stroke

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark Robert Milner, M.D.

29c. License number

M0 041520

29d. Date signed (Month, Day, Year)

4/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6416 Recreation Dr

Bethesda MD

MARK MILNER MD

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12650

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |  |  |  |
|---|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MILDRED E. BELSER  |   |   |  | 2. Date of Death<br>Month Day Year<br>04 06 1997   |  | 3. Time of Death<br>4:00 A.M.                                    |  |
|   | 4e. Facility Name (If not Institution, give street and number)<br>12517 TRIPLE CROWN ROAD  |   |   |  | 4b. City, Town, or Location of Death<br>DARNESTOWN   |  | 4c. County of Death<br>MONTGOMERY                                |  |
| Funeral<br>Director   | 5. Social Security Number<br>103-14-9162   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>73 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>10/21/1923                |  |
|   | 9. Birthplace (State or Foreign Country)<br>NEW YORK   |   | 10a. State<br>MARYLAND  |  | 10b. County<br>MONTGOMERY  |  | 10c. City, Town or Location<br>GAITHERSBURG                      |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br>409 CHRISTOPHER AVENUE APT. #13   |  | 10f. Zip Code<br>20870   |  | 10g. Citizen of What Country?<br>U.S.A.                          |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>SECRETARY                                |  | 16b. Kind of Business/Industry<br>ELECTRONICS  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>FREDERICK GROTZ   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>FLORENCE ARCHER   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>CHARLENE LINDENBAUM (DAUGHTER)   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12517 TRIPLE CROWN ROAD DARNESTOWN, MARYLAND 20878  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MT. COMFORT CREMATORY   |  | 20c. Location - City or Town, State<br>ALEXANDRIA, VIRGINIA  |  | 20d. Date<br>4/12/97   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br>1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>s. ADENOCARCINOMA OF UNKNOWN ORIGIN<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |   |   |  | Approximate Interval Between Onset and Death<br>WEEKS  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br>D41866  |  | 29d. Date signed (Month, Day, Year)<br>APRIL 7, 1997                                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>KANAN HUDUD - 481 N. FREDERICK AVENUE, STE. 230 - GAITHERSBURG, MARYLAND 20877  |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 10 1997  |  | 32. Registrar's Signature<br>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

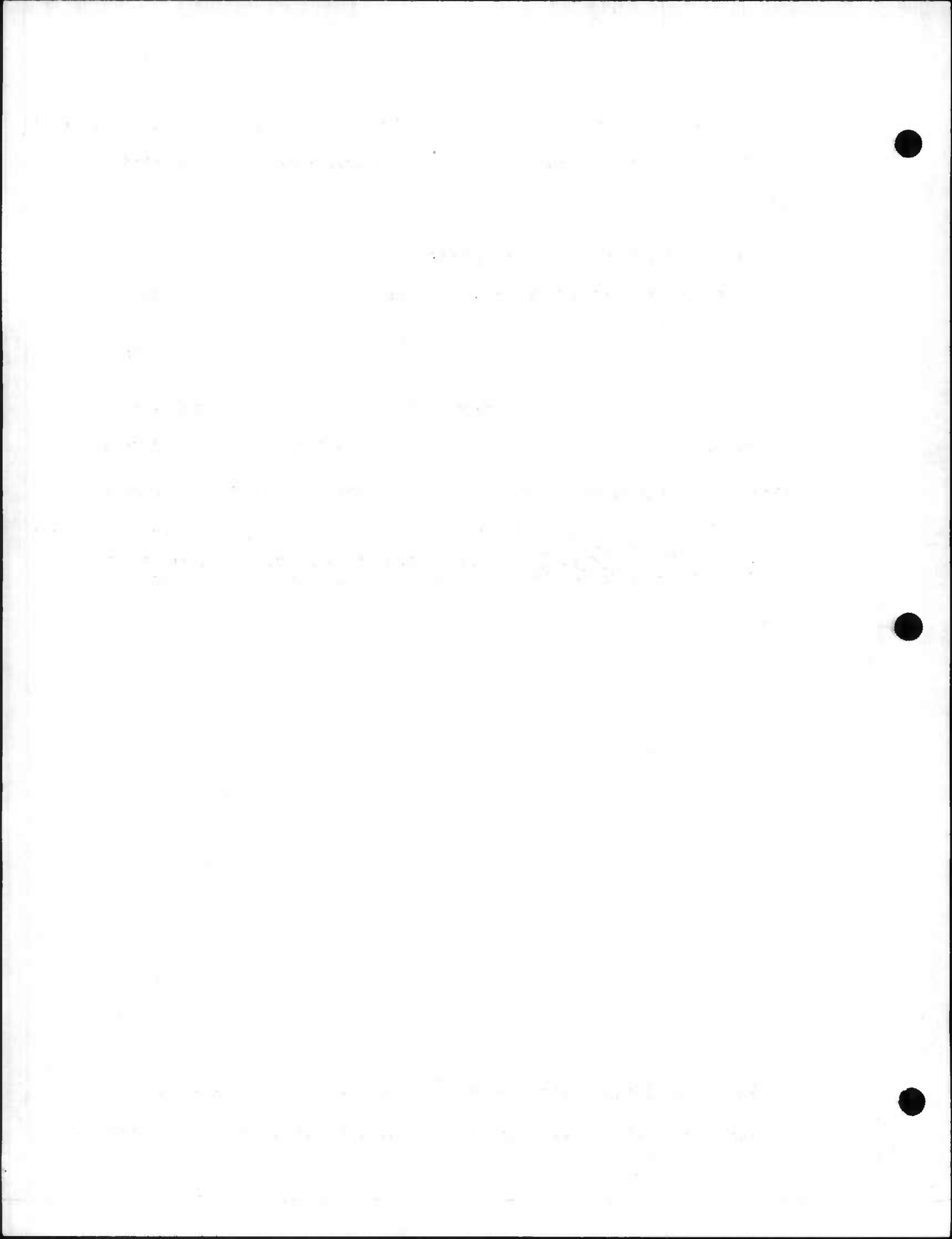
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12651

Certificate of Death

Reg. No.

|   |  |  |   |  |   |                                |  |   |
|---|--|--|---|--|---|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Frances Barnes</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 2, 1997</b>  |                                | 3. Time of Death<br><b>19:20 PM</b>  |   |
|   | 4e. Facility Name (If not Institution, give street and number)<br><b>Montgomery General Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Olney</b>  |                                | 4c. County of Death<br><b>Montgomery</b>   |   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>185-32-3134</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>April 16, 1940</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |
|   | Usual Residence of Decedent  |  |   |  |   |                                |  |   |
| To Be Completed by Funeral Director           | 10e. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Olney</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>18813 Briars Court</b>  |  |   |  | 10f. Zip Code<br><b>20832</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bank Teller</b>                   |  | 16b. Kind of Business/Industry<br><b>Banking</b>  |                                |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Nicholas Scioli</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Viola DiTullio</b>  |                                |  |   |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald E. Barnes</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18813 Briars Court Olney, Maryland 20832</b>  |                                |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Norbeck Memorial Park</b>  |  | 20c. Location - City or Town, State<br><b>04/06/97 Olney, Maryland</b>  |                                | 20d. Date  |   |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W., Silver Spring, MD 20901</b>  |                                |  |   |
|   | 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiogenic Shock</b><br>Due to (or as a consequence of):<br><b>b. Sepsis</b><br>Due to (or as a consequence of):<br><b>c. Group C Streptococcal Infection</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |   |                                |  |   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |                                |  |   |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                |  |   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  |   |                                |  |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |                                |  |   |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |                                |  |   |
|   | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D37930</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>April 3, 1997</b>                                    |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT H. KNITZER, MD 1811 Prince Philip Dr #312 OLNEY, MD 20832</b>  |  |   |  |   |                                |  |   |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>APR 07 1997</b>  |  |   |  | 32. Registrar's Signature<br>   |                                |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12652

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Nelson Bulleit

2. Date of Death

April 7, 1997

3. Time of Death

8:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6403 Orchid Drive

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

168-14-1371

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 9, 1921

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6403 Orchid Drive

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII &amp; Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Senior Staff Assistant

16b. Kind of Business/Industry

U. S. Senate

17. Father's Name (First, Middle, Last)

Eugene Verner Bulleit

18. Mother's Name (First, Middle, Maiden Surname)

Mary DeVol

19a. Informant's Name/Relationship (Type, Print)

Jeanne P. Bulleit

Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6403 Orchid Drive, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

4-8-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Emphysema

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 yrs.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

2 yrs.

c. Cardiomyopathy

Due to (or as a consequence of):

2 yrs.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Guillain-Barre type syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ylene A. Larsen M.D.

29c. License number

B93540

29d. Date signed (Month, Day, Year)

April 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ylene A. Larsen, M.D., 5454 Wisconsin Ave., #1125, Chevy Chase, Maryland 20815-6902

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

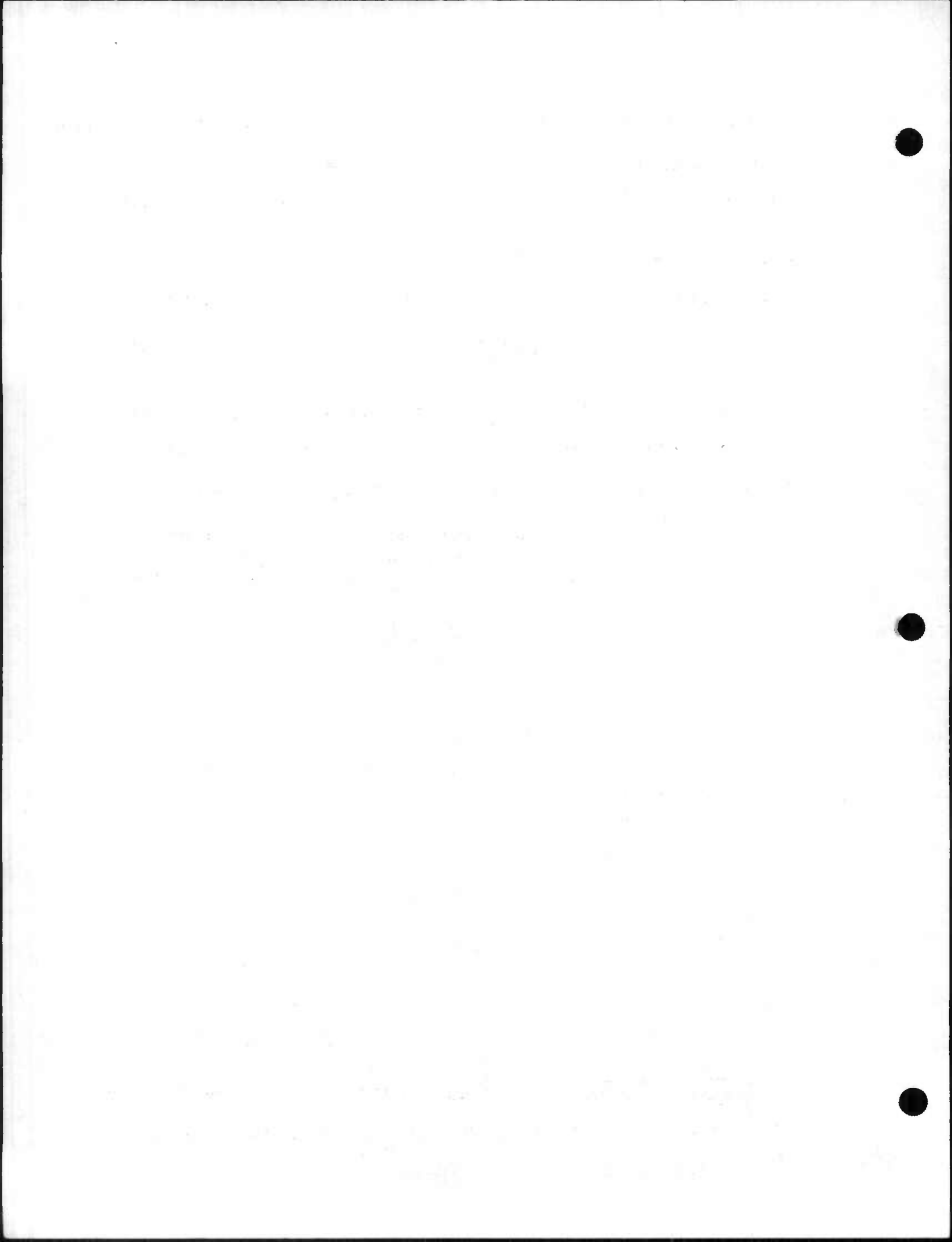
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12653

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Alfred Bowler

2. Date of Death

Month Day Year  
April 6, 1997

3. Time of Death

11:40 A.M.

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-20-9565

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 2, 1923

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14500 Myer Terrace

10f. Zip Code

20853

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Postal Supervisor

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Frank Carol Bowler

18. Mother's Name (First, Middle, Maiden Surname)

Naomi Pearl Conaway

19a. Informant's Name/Relationship (Type, Print)

Lee Frances Bowler/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14500 Myer Terrace, Rockville, Maryland 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parklawn Memorial Park

Date

April 10, 1997

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta M00348

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 W. Montgomery Avenue,  
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. metastatic lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

M

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael P. Kutta MD

29c. License number

D21531

29d. Date signed (Month, Day, Year)

April 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Peter Pushkas MD 11510 Old Georgetown Rd. Rockville MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10 + 19





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12654

Amended #18, 4/16/97, JW, Montg. Co.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SYLVIA MIRIAM (MARCUS) BRODSKY

2. Date of Death

Month Day Year  
APRIL 2, 1997

3. Time of Death

11:41PM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-03-1252

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
MARCH 20, 1919

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6111 MONTROSE ROAD #201

10f. Zip Code

20852

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BOOKKEEPER

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

ABRAHAM MARCUS

18. Mother's Name (First, Middle, Maiden Surname)

DEBORAH ROSE SILVERBURG SILVERBERG

19a. Informant's Name/Relationship (Type, Print)

FRANCINE JOYNER (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19005 GOLD MINE PLACE - BROOKVILLE, MARYLAND 20833

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH SHOLOM CEMETERY

Date

4/4/97

20c. Location - City or Town, State

CAPITOL HGTS., MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.  
1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

WEEKS

f. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

YEARS

g. ATRIAL FIBRILLATION

Due to (or as a consequence of):

YEARS

h. SYSTEMIC EMBOLIZATION

18 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERITONITIS, RENAL INSUFFICIENCY, PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D36787

29d. Date signed (Month, Day, Year)

4-2-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ALAN R. SHEFF, MD - 10215 FERNWOOD ROAD #100 - BETHESDA, MARYLAND 20817

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12655

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LARRY DEAN BREEDING

2. Date of Death  
Month Day Year  
APRIL 9, 19973. Time of Death  
5:56 a.m.

4a. Facility Name (If not institution, give street and number)

NATIONAL INSTITUTE OF HEALTH

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

263-13-5522

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

DEC. 22, 1952

9. Birthplace (State or Foreign Country)

CALIFORNIA

Usual Residence of Decedent

10a. State  
FLORIDA10b. County  
DUVAL10c. City, Town or Location  
JACKSONVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1050 GRANGER DRIVE

10f. Zip Code

32221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

AIR TRAFFIC CONTROLLER

16b. Kind of Business/Industry

U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)

BUSTER EUGENE BREEDING

18. Mother's Name (First, Middle, Maiden Surname)

RUBY-MARIE LOCKRIDGE

19a. Informant's Name/Relationship (Type, Print) FUNERAL  
RICHARD HARDAGE, DIRECTOR19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
729 S. EDGEWOOD AVE., JACKSONVILLE FL 32210

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RIVERSIDE MEMORIAL PARK

Date

4/14/97

20c. Location - City or Town, State

RIVERSIDE MEMORIAL PARK, JACKSONVILLE, FL

21. Signature of Funeral Service Licensee

22. Name and Address of Facility JOSEPH GAWLER'S SONS INC.

5130 WISCONSIN AVE. NW WASHINGTON, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute respiratory distress syndrome

Days

Due to (or as a consequence of):

b. metastatic malignant melanoma

months

Due to (or as a consequence of):

c. renal failure

weeks

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD18992-02

29d. Date signed (Month, Day, Year)

4/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Catherine A Martin 9000 ROCKVILLE PIKE BETHESDA, MARYLAND 20892

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12656

## Certificate of Death

Reg. No.

|  |  |   |   |                                |  |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|--|--|---|---|--------------------------------|--|--|--|--|---|----|----------------------------|---------|----|----------------------------------|----------|----|--|--|----|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Lena B. Bayardi  |   |   |                                | 2. Date of Death<br>Month Day Year<br>April 5, 1997  |  | 3. Time of Death<br>9:20 p.m.                                    |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Manor Care, Bethesda   |   |   |                                | 4b. City, Town, or Location of Death<br>Chevy Chase  |  | 4c. County of Death<br>Montgomery                                |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
| Funeral<br>Director  | 5. Social Security Number<br>577-05-6998   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                | 7. Age (in yrs. last birthday)<br>95 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Sept. 28, 1901            |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | 9. Birthplace (State or Foreign Country)<br>Virginia   |   | 10a. State<br>NA  |                                | 10b. County<br>NA  |  | 10c. City, Town or Location<br>Washington, D.C.                  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   |   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | 10e. Street and Number<br>1500 Massachusetts Ave. N.W.   |   |   |                                | 10f. Zip Code<br>20005   |  | 10g. Citizen of What Country?<br>U.S.A.                          |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 2 College (1-4 or 5+)   |   |   |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Jeweller  |  | 16b. Kind of Business/Industry<br>Jewelry                        |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | 17. Father's Name (First, Middle, Last)<br>Archibald Black   |   |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Barbara Lou Layman  |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Edward Hall Trustee  |   |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>607 15th Street, N.W. Washington, DC 20005  |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |                                | Data<br>4/11/97  |  | 20c. Location - City or Town, State<br>Suitland, Maryland        |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |                                | 22. Name and Address of Facility Joseph Gawler's Sons, Inc.<br>5130 Wisconsin Avenue, NW Washington, D.C.<br>20016   |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |                                |  |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Cerebral Vascular Accident</td> <td>2 Weeks</td> </tr> <tr> <td>b.</td> <td>Cerebral Artery Arteriosclerosis</td> <td>20 years</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |   |   |                                |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Cerebral Vascular Accident | 2 Weeks | b. | Cerebral Artery Arteriosclerosis | 20 years | c. |  |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | a.   | Cerebral Vascular Accident  | 2 Weeks   |                                |  |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | b.   | Cerebral Artery Arteriosclerosis  | 20 years  |                                |  |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | c.   |   |   |                                |  |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  | d.   |   |   |                                |  |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |                                |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  |  |   |   |                                |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  |  |   |   |                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                |  |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
|  |  | 28d. Describe how injury occurred   |   |                                |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br>D 13187 |  | 29d. Date signed (Month, Day, Year)<br>April 7, 1997   |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. Neill Kennedy M.D. 5530 Wisconsin Avenue, Chevy Chase, Maryland 20815   |  |   |   |                                |  |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |
| 31. Date filed (Month, Day, Year)<br>APR 10 1997   |  | 32. Registrar's Signature<br>   |   |                                |  |  |  |  |   |    |                            |         |    |                                  |          |    |  |  |    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12657

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HENRY J.

BUNISKI

2. Date of Death

Month Day Year  
APRIL 14 1997

3. Time of Death

3:41 PM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

066-22-1682

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 1, 1925

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

QUEEN ANNE

10c. City, Town or Location

QUEENSTOWN

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

411 WYE EAST LANE

10f. Zip Code

21658

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

DEVELOPER

16b. Kind of Business/Industry

HOMES

17. Father's Name (First, Middle, Last)

CHARLES BUNISKI

18. Mother's Name (First, Middle, Maiden Surname)

SARAH SZYLARCZYK

19a. Informant's Name/Relationship (Type, Print)

MILDRED BUNISKI/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

411 WYE EAST LANE, QUEENSTOWN, MD 21658

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ST. PETERS CEMETERY

Date

4-18

20c. Location - City or Town, State

QUEENSTOWN, MD

21. Signature of Funeral Service Licensee

JOHN R. MERCERON CFS

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME  
200 S. HARRISON ST., EASTON, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARDIAC ARREST

Approximate  
Interval Between  
Onset and Death

IMMEDIATE

Due to (or as a consequence of):

b. ? SEPSIS

? DAY

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. PROBABLE INFECTED RIGHT HIP PROSTHESIS

DAYS

Due to (or as a consequence of):

d. RIGHT HIP REPLACEMENT

11 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

David B. Danner MD

29c. License number

D 50502

29d. Date signed (Month, Day, Year)

April 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David B. Danner MD 219 S. Washington St. Easton, MD 21601

31. Date filed (Month, Day, Year)

APR 16 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12658

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALLEN LEE BROTEMARKLE

2. Date of Death

Month Day Year  
APRIL 17 1997

3. Time of Death

6:25 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL &amp; MEDICAL CENTER

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

218-16-3430

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT 1 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

326 PEAR STREET

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates: WW1113. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

MANAGER OF R.P.S. AUTO PARTS

16b. Kind of Business/Industry

RETAIL/AUTO PARTS

17. Father's Name (First, Middle, Last)

RALPH R. BROTEMARKLE

18. Mother's Name (First, Middle, Maiden Surname)

NORA MARGARET HENDRICKSON

19a. Informant's Name/Relationship (Type, Print)

JEAN A. BROTEMARKLE WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

326 PEAR STREET CUMBERLAND MARYLAND 21502

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SUNSET CEMETERY APRIL 21 1997

Date

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dole L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Acute Myocardial Infarction

24 hours

Due to (or as a consequence of):

b. Acute Pneumonia

24 hours

Due to (or as a consequence of):

c. Acute Respiratory Failure

24 hours

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cancer of Liver

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician

29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Shah

29c. License number

D 23334

29d. Date signed (Month, Day, Year)

18th April 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DINESH SHAH M.D., 625 KENT AVE., CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

APR 21 1997

32. Registrar's Signature

John H. H. H.

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



97 12659

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lucile F. Boden</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>15</b> YEAR <b>97</b>  |  | 3. TIME OF DEATH<br><b>12:40 A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-36-7752</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 21, 1901</b>  |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Allegany County Nursing Home</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>   |  | 8c. COUNTY OF DEATH<br><b>Allegany</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Allegany</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>777 MacDonald Teerace</b>   |  |  |  | 10f. ZIP CODE<br><b>21502</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                               |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Manager</b>                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Credit Union</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert L. Frantz</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Effie M. (Wickard)</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sandra B. Haus</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>809 Sylvan Ave., Cumberland, MD. 21502</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of facility, crematory or other place)<br><b>Hickcrest Memorial Park 4/17/97 Cumberland, MD.</b>    |  | 20c. LOCATION — City or Town, State<br><b>4/17/97 Cumberland, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>William S. R...</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Right Funeral Home<br/>309-311 Decatur St., Cumberland, MD 21502</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>RENAL FAILURE, CHRONIC</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  | Approximate Interval Between Onset and Death<br><b>4 MOS.</b>   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  | b. <b>NEPHRO SCLEROSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  | 4 MOS.  |  |
|  |  | c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |
|  |  | d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. J. Somers, Jr.</i>  |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APRIL 16, 1997</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ROBUSTIANO J. BARRERA ALLEG. CO. NURSING HOME, CUMB. MD</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 17 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Johanna...</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12660

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James Callahan

2. Date of Death

04

02

97

3. Time of Death

9:16pm

4a. Facility Name (If not institution, give street and number)

1412 East Central Ave

4b. City, Town, or Location of Death

Edgewater

4c. County of Death

Anne Arundel

5. Social Security Number

217-38-8348

6. Sex

M

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

03-20-41

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Edgewater

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1412 East Central Ave.

10f. Zip Code

21037

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 60/63

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

No

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Essie Wilson Callahan

18. Mother's Name (First, Middle, Maiden Surname)

Ora Pardue

19a. Informant's Name/Relationship (Type, Print)

Ora E. Callahan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1412 East Central Ave. Edgewater Md. 21037

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

April 7, 1997

Maryland Veterans Cemetery

Date

20c. Location - City or Town, State

Crownsville Md.

21. Signature of Funeral Service Licensor

Robert E. Evans, Pres.

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Large cell Cancer of lung

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stuart E. Selouch

29c. License number

01983

29d. Date signed (Month, Day, Year)

4/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart E. Selouch, M.D. 900 Bestgate Annapolis, md 21401

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

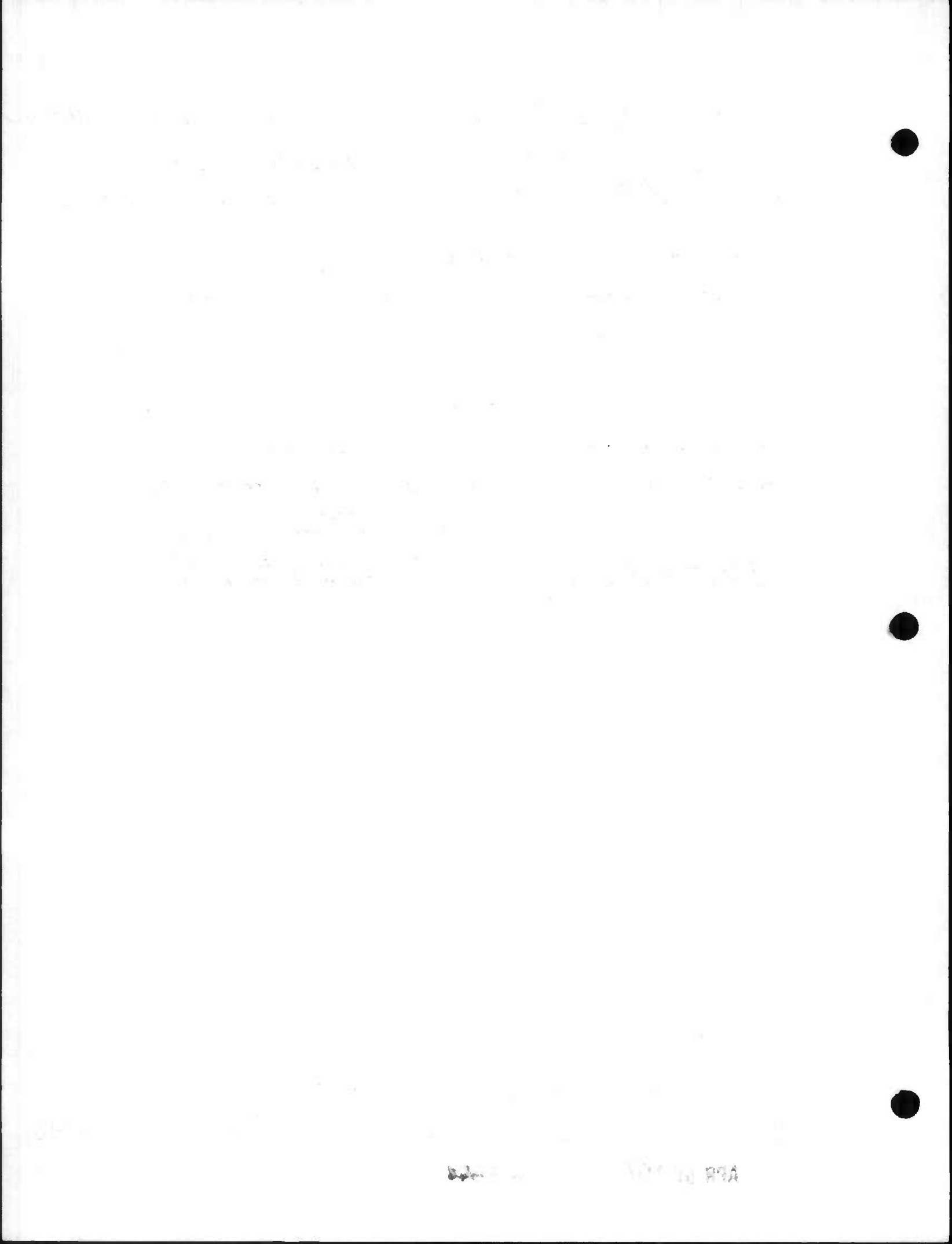
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12661

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dandolo Chiodaroli

2. Date of Death

Month Day Year  
April 5 1997

3. Time of Death

2:50 PM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

092 18 5628

6. Sex

M 20 F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Sept. 2, 1924

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

Yes 2 No

10e. Street and Number

12400 Chelton Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
Yes 2 No  
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Systems Analyst

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Angelo Chiodaroli

18. Mother's Name (First, Middle, Maiden Surname)

Ida Pollarola

19a. Informant's Name/Relationship (Type, Print)

Concetta Chiodaroli Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12400 Chelton Lane Bowie Maryland 20715

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)April 9, 1997  
Sacred Heart Church Cemetery

20c. Location - City or Town, State

Bowie Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.  
16000 Annapolis Rd. Bowie Maryland 2071523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. pneumonia  
Due to (or as a consequence of)b. squamous cell carcinoma lung  
Due to (or as a consequence of)c. COPD  
Due to (or as a consequence of)

d.

Approximate  
Interval Between  
Onset and Death1 week  
with  
xrs.Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

Hospital:

Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
investigation  
2 Accident 6 Could not be  
determined  
3 Suicide  
4 Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Catavenis MD P.G. Hospital, Cheverly Maryland

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

John A. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

chiodaroli



100% Recycled  
Paper  
100% Recycled  
Paper  
100% Recycled  
Paper



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12662

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Verniece R. Crehan

2. Date of Death

April 7 1997 12:00 PM

3. Time of Death

12:00 PM

4a. Facility Name (If not institution, give street and number)

Annapolis Nursing Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

578 05 6508

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs

Hours Min.

8. Date of Birth

May 26, 1912

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10e. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Davidsonville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1283 Lavall Drive

10f. Zip Code

21035

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

1 College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Beautician

16b. Kind of Business/Industry

Hair Care

17. Father's Name (First, Middle, Last)

Vernon E. Torney

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Andrews

19a. Informant's Name/Relationship (Type, Print)

Marlene Rodriguez Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1283 Lavall Drive Davidsonville Maryland 21035

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

April 11, 1997

20c. Location - City or Town, State

Alexandria Va.

21. Signature of Funeral Service Licensee

Robert E. Evans Pres

22. Name and Address of Facility

Robert E. Evans Funeral Home Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multi-infarct dementia

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

many years

many years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard I. Hochman MD

29c. License number

DO 5192

29d. Date signed (Month, Day, Year)

4/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard I. Hochman MD 1833 A Forest Dr, Annapolis, Md 21401

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

Julia Swales-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

③



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12663

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |   |  |   |   |
|---|--|---|---|--|---|---|
| 1. Decedent's Name (First, Middle, Last)<br>Elsie M. Chapman  |  |   | 2. Date of Death<br>Month Day Year<br>April 8, 1997   |  | 3. Time of Death<br>1:00 P.M.   |   |
| 4a. Facility Name (If not institution, give street and number)<br>Manor Care Health Services  |  |   | 4b. City, Town, or Location of Death<br>Largo   |  | 4c. County of Death<br>Prince George's  |   |
| 5. Social Security Number<br>219-48-3589  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>96  | 8. Date of Birth (Month, Day, Year)<br>Oct. 3, 1900  | 9. Birthplace (State or Foreign Country)<br>Virginia  |   |
| Usual Residence of Decedent   |  |   |   |  |   |   |
| 10a. State<br>Maryland  |  | 10b. County<br>Prince George's  |   | 10c. City, Town or Location<br>Suitland  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
| 10e. Street and Number<br>4860 Huron Avenue   |  |   | 10f. Zip Code<br>20746  |  | 10g. Citizen of What Country?<br>U.S.A.   |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6<br>College (1-4 or 5+)   |  |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |  | 16b. Kind of Business/Industry<br>Own Home  |   |
| 17. Father's Name (First, Middle, Last)<br>William Henry Miller   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lula May Patterson   |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Beulah M. Pruett/Daughter   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>same as item 10      |  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |   | Date<br>4/11/97  | 20c. Location - City or Town, State<br>Suitland, Maryland                                       |   |
| 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br>George P. Kalas Funeral Home<br>6160 Oxon Hill Rd. Oxon Hill, Md. 20745           |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Alzheimer's Disease</u><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   | Approximate Interval Between Onset and Death<br>4 yrs   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Alzheimer's Disease</u>  |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |   |   |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |   |   |
| 29b. Signature and title of certifier<br>   |  |   | 29c. License number<br>732261   |  | 29d. Date signed (Month, Day, Year)<br>4-8-97   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Richard J. Feldman, M.D. 9500 Annapolis Road, Lanham, Maryland 20706  |  |   |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br>APR 11 1997  |  |   | 32. Registrar's Signature<br>   |  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12664

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Frances Lucille Cope

2. Date of Death

Month Day Year  
April 13, 1997

3. Time of Death

10:00am

4a. Facility Name (If not Institution, give street and number)

2412 Marbourne Avenue Apartment 2B

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

409-48-4614

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 5, 1933

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2412 Marbourne Avenue Apt. 2B

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Floyd Bagley

18. Mother's Name (First, Middle, Maiden Surname)

Maude Churchwell

19a. Informant's Name/Relationship (Type, Print)

Mr. Richard B. Cope (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7124 Brangles Road, Marriottsville, MD 21104

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Serv.

Date

4/15/97

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

Brian L. Haught

22. Name and Address of Facility

HAIGHT FUNERAL HOME &amp; CHAPEL (Box 195)

Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

METASTATIC CARCINOMA of UNKNOWN PRIMARY

Approximate Interval Between Onset and Death

3 1/2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19419

29d. Date signed (Month, Day, Year)

APRIL 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DIANA H. GRIFFITH 900 CATON AVE. BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

APR 15 1997

32. Registrar's Signature

Julia Anderson-Rodall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12665

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Audrey Lee Covey

2. Date of Death

Month

Day

Year

April 12 1997

6:30 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

585-14-5175

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Apr. 13, 1940

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11400 Stonecroft Ct. Apt. 308B

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Stewart Milton Bennett

18. Mother's Name (First, Middle, Maiden Surname)

Lola Arlene King

19a. Informant's Name/Relationship (Type, Print)

Daisy V. Berkebile (Friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11400 Stonecroft Ct. Apt. 308B Hagerstown, Md. 21742

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

April 13, 1997

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Director

22. Name and Address of Facility

Davis Funeral Home  
12525 Bradbury Ave.  
Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory Failure

Due to (or as a consequence of):

End-stage COPD

Due to (or as a consequence of):

Pneumonia

Due to (or as a consequence of):

Cor Pulmonale

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

2 wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40131

29d. Date signed (Month, Day, Year)

4/12/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOHN A. CORPECES, M.D.

338 mill st.  
Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

APR 14 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Amed #17 Wash. Co. & B April 15, 1997  
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12666

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Janet Marie Cuddy   |  | 2. Date of Death<br>Month Day Year<br>April 11, 1997   |  | 3. Time of Death<br>17:26 pm   |  |
| 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital  |  | 4b. City, Town, or Location of Death<br>Hagerstown   |  | 4c. County of Death<br>Washington  |  |
| 5. Social Security Number<br>214-46-5520  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>77 Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br>Dec. 14, 1919  |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  |  |  |
| Usual Residence of Decedent   |  |  |  |  |  |
| 10a. State<br>Maryland  |  | 10b. County<br>Washington  |  | 10c. City, Town or Location<br>Hagerstown  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |  |
| 10e. Street and Number<br>300 Northern Avenue   |  | 10f. Zip Code<br>21742   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: white  |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>0-8   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>homemaker   |  | 16b. Kind of Business/Industry<br>own home   |  |
| 17. Father's Name (First, Middle, Last)<br>Ralph David Ridgley  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Louise Elenora Yeager   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Donna M. Kesecker/Daughter   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10292 Gaywood Drive, Hagerstown, Maryland 21740   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery  |  | 20c. Location - City or Town, State<br>Apr. 16, 1997 Hagerstown, Maryland  |  |
| 21. Signature of Funeral Service Licensee<br>Scott M. Minnich   |  | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 East Wilson Blvd., Hagerstown, Maryland 21740  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sepsis<br>Due to (or as a consequence of):<br>Intra abdominal infection<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Coronary Artery Disease<br>Chronic Renal Failure |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>J. Carbonell  |  | 29c. License number<br>047942  |  |
| 29d. Date signed (Month, Day, Year)<br>April 11, 1997   |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Juan A. Carbonell<br>12931 Oak Hill Avenue, Hagerstown, MD 21740  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 15 1997  |  | 32. Registrar's Signature<br>John A. Carbonell   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12667

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICK HENRY COLEMAN

2. Date of Death

April 9 1997 1018 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

156 03 9933

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCTOBER 12, 1919

9. Birthplace (State or Foreign Country)

N. J.

Usual Residence of Decedent

10a. State MARYLAND WASHINGTON

10b. County

10c. City, Town or Location HAGERSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19105 SHAMROCK LANE

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES MANAGER

16b. Kind of Business/Industry

AERONAUTICAL PARTS

17. Father's Name (First, Middle, Last)

HARRY

COLEMAN

18. Mother's Name (First, Middle, Maiden Surname)

CAROLINE

WORTH

19a. Informant's Name/Relationship (Type, Print)

KATHRYN S. COLEMAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19105 SHAMROCK LANE HAGERSTOWN, MD. 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLLYWOOD MEMORIAL PK. 97

Date

4/14

20c. Location - City or Town, State

UNION, N. J.

21. Signature of Funeral Service Licensee

Gerald N. Minnich

22. Name and Address of Facility

GERALD N. MINNICH  
FUNERAL HOME305 N. POTOMAC ST.  
HAGERSTOWN, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. SUDDEN DEATH

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
FEW MINUTES

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

2-3 YEARS

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

MORE THAN 5 YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pamela Fox Bradford

29c. License number

D38892

29d. Date signed (Month, Day, Year)

4/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAMELA FOX BRADFORD MD SUITE 130 1110 MEDICAL CAMARUS RD. HAGERSTOWN, MD 21742

31. Date filed (Month, Day, Year)

APR 15 1997

32. Registrar's Signature

Julie Anderson-Russell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12668

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Veronica CLARK

2. Date of Death

Month Day Year  
April 2, 1997

3. Time of Death

1:20AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

219-82-2604

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

37 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 14, 1959

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Palmer Park

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

7600 Normandy Road

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Food Service Worker

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Edward Clark

18. Mother's Name (First, Middle, Maiden Surname)

Mable Thomas

19a. Informant's Name/Relationship (Type, Print)

Mable Clark

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7600 Normandy Rd. Palmer Park, MD 20785

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

4/5/97

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

*J. P. Marshall*

22. Name and Address of Facility

Marshall's Funeral Home Inc.  
4217 9th Street N.W. Wash DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acquired Immune Deficiency Syndrome

Due to (or as a consequence of):

b. Bilateral Extensive pneumonia

Due to (or as a consequence of):

c. Pneumothorax R. Lung

Due to (or as a consequence of):

d. multi microbial sepsis

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Respiratory failure

2 Very low CD4 cells

3 Anaemia 4 History of IV Drug use

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*S.R. Udapi*

29c. License number

D21200

29d. Date signed (Month, Day, Year)

April 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHRINIVAS R. UDAPI, MD 7245. B HANOVER PK Y GREEN BELT, MD

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

*John Andrew Russell*

20770

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



97 12669

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT LEE COHEY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 10 1997</b>   |  | 3. TIME OF DEATH<br><b>1:50 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-44-6444</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>51 YRS.</b>   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>03/19/46</b>                           |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Wesleyan Health Care Ctr.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Denton</b>                             |  |
| 9c. COUNTY OF DEATH<br><b>Caroline</b>  |  |  |  | 10a. STATE<br><b>MD</b>  |  |  |  |
| 10b. COUNTY<br><b>Caroline</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Federalsburg</b>   |  |  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>124 Liberty Road</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21632</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Truck Driver</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Trucking</b>                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel Cohey</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elsie Mae Quillen</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Eileen Turbitt</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>124 Liberty Rd., Federalsburg, MD 21632</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Concord Cemetery</b>   |  | DATE<br><b>4-15</b>  |  | 20c. LOCATION — City or Town, State<br><b>Federalsburg, MD</b>                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Michael F. Eskow</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Frampton-Hawkins-Eskow Funeral Home<br/>PO Box 43, Federalsburg, MD 21632</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br><b>Diabetic Nephropathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Diabetes Mellitus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension, Stroke, Electrolyte Imbalance, Diabetes Mellitus</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>3 mos</b> |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Jeff Denton MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D47492</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/10/97</b>                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jeff Denton MD PO Box 122 Goldsboro MD 21636</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 14 1997</b>   |  |  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12670

## Certificate of Death

Reg. No.

|                                     |  |  |  |  |  |  |   |  |  |  |
|-------------------------------------|--|--|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DOROTHY AGNES CARTER</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 13 1997</b>   |  |   |  | 3. Time of Death<br><b>1:52 P. M.</b>  |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>12519 RICHFIELD AVE.</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>CORRIGANVILLE</b>   |  |   |  | 4c. County of Death<br><b>ALLEGANY</b>   |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>220 74 9161</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  |
|                                     | 8. Date of Birth (Month, Day, Year)<br><b>JAN 15 1908</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ALLEGANY</b>  |  | 10c. City, Town or Location<br><b>CORRIGANVILLE</b>  |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>12519 RICHFIELD AVE.</b>  |  | 10f. Zip Code<br><b>21524</b>  |  | 10g. Citizen of What Country?<br><b>U. S.</b>   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |
|                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>12</b> |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>   |  |
|                                     | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>JOHN THOMAS CHAMBERS</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARGARET ELLEN TIGHE</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROSE RINGER/DAUGHTER</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12519 RICHFIELD AVE., CORRIGANVILLE, MD 21524</b>  |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. MICHAEL CEMETERY</b>  |  | Date<br><b>4/16/97</b>   |  | 20c. Location - City or Town, State<br><b>FROSTBURG, MD 21532</b>   |  | 21. Signature of Funeral Service Licensee<br><i>Maribou M. Sowers</i>  |  |
|                                     | 22. Name and Address of Facility<br><b>SOWERS FUNERAL HOME, P.A.</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CONGESTIVE HEART FAILURE</b> |  | Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death<br><b>ONE WEEK</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |
|                                     | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                 |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>James A. Moore</i>  |  | 29c. License number<br><b>D33417 (MO)</b>  |  |
|                                     | 29d. Date signed (Month, Day, Year)<br><b>APRIL 14 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>1068 NATIONAL HIGHWAY LAVALLE, MD 21092 (JAMES K. MOORE, M.D.)</b>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>  |  | 32. Registrar's Signature<br><i>John D. ...</i>   |  | State Registrar  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

201  
100

100

100

100

100

100

100

100

100

100

100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12671

## Certificate of Death

Reg. No.

|   |   |  |   |   |   |
|---|---|--|---|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>DONALD MORRIS CROWLEY JR.   |  | 2. Date of Death<br>Month: APRIL Day: 02 Year: 1997   |   | 3. Time of Death<br>2103 P  |
|   | 4a. Facility Name (If not institution, give street and number)<br>HOWARD COUNTY GENERAL HOSPITAL  |  | 4b. City, Town, or Location of Death<br>COLUMBIA  |   | 4c. County of Death<br>HOWARD   |
| Funeral<br>Director   | 5. Social Security Number<br>218-90-3995  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                           | 7. Age (In yrs. last birthday)<br>34 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>Nov. 21, 1962  | 9. Birthplace (State or Foreign Country)<br>Washington, D.C.  |
|   | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Germantown   |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>18032 Chalet Drive Apt. 102   |   | 10f. Zip Code<br>20874  |
|   | 10g. Citizen of What Country?<br>U.S.A.   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1983-1984   |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Brick Mason  |  | 16b. Kind of Business/Industry<br>Construction  |   | 17. Father's Name (First, Middle, Last)<br>Donald Morris Crowley, Sr.   |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rosemary Ann Aquilino  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Laura Jean Crowley  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>18032 Chalet Drive #102 Germantown, Maryland 20874   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery   |   | 20c. Location - City or Town, State<br>Silver Spring, Maryland  |
|   | 21. Signature of Funeral Service Licensee<br>William L. Byrd  |  | 22. Name and Address of Facility<br>Francis J. Collins Funeral Home, Inc.<br>500 University Blvd., W., Silver Spring, MD 20901  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Multiple Injuries  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |
|   | 28a. Date of Injury (Month, Day, Year)<br>4-2-97  |  | 28b. Time of Injury<br>2:00 M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 28d. Describe how injury occurred.<br>Driver in auto accident   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Street         |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>M. Blvd Rt. 29 - N. of E. 175 |   |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>[Signature]   |   | 29c. License number<br>O.C.M.E  |   |
| 29d. Date signed (Month, Day, Year)<br>APRIL 03, 1997   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>TILARON LOKE, MD |   | 31. Date filed (Month, Day, Year)<br>APR 08 1997  |   |
| 32. Registrar's Signature<br>Julia Davidson-Rodella   |   | 33. Date of Death<br>APRIL 03, 1997  |   | 34. Time of Death<br>2103 P   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 12672**  
 Amend #5 4/15/97 JW, Mont. Cty.  
 Amended #7, 4/11/97, JW, Montg. Cty. **Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Germaine

J.

Cassou

2. Date of Death

April 9, 1997

3. Time of Death

1:15 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

225-10-1524

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 101 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 8, 1896

9. Birthplace (State or Foreign Country)

POITIERS, FRANCE

Usual Residence of Decedent

10e. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9701 MEDICAL CENTER DRIVE

10f. Zip Code

20850

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JEAN COMPAGNON

18. Mother's Name (First, Middle, Maiden Surname)

LEONTYNE TRIC

19a. Informant's Name/Relationship (Type, Print)

DENISE HEARING DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1378 KERSEY LANE POTOMAC, MARYLAND 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MOUNT OLIVET CEMETERY

Date

4/12/97

20c. Location - City or Town, State

WASHINGTON, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.

5130 Wisconsin Ave. NW WDC 20016

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heat/failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

ALZHEIMER'S SYNDROME

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

a.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Byrl D. Johnson MD

29c. License number

019042

29d. Date signed (Month, Day, Year)

APRIL 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BYRL D. JOHNSON MD 911 RUSSELL AVE. GAITHERSBURG MARYLAND 20879

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

J. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12673

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |   |  |  |
|---|--|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ANNE BARBARA COYNE</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>April 4, 1997</b>  |   | 3. Time of Death<br><b>0945</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GEORGIA &amp; HEWITT</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b>  |   | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>011-10-7625</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 11, 1917</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Massachusetts</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>728 Springloch Road</b>   |  | 10f. Zip Code<br><b>20904</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Real Estate Agent</b>  |  | 16b. Kind of Business/Industry<br><b>Real Estate</b>  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Patrick Corrigan</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Joyce</b>  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert J. Coyne</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>800 Tanley Road Silver Spring, Maryland 20904</b>   |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>4/08/97 Silver Spring, Maryland</b>   |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W., Silver Spring, MD 20901</b>  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Multiple injuries</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |  |  |   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |  |  |  |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |  |   |   |  |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>4-4-97</b>  |  | 28b. Time of Injury<br><b>0945 M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   | 28d. Describe how injury occurred<br><b>Passenger single car accident</b>  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Street</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Georgia Ave at Hewitt Wheaton, Montgomery Co. MD</b>   |   |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |   |  |  |
|   | 29b. Signature and title of certifier<br><b>Donald G. Wright MD</b>  |  |  |  | 29c. License number<br><b>O.C.M.E.</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 5, 1997</b>  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DONALD G. WRIGHT MD 111 Penn St., Baltimore, MD 21201</b>   |  |  |  |   |   |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 08 1997</b>  |  | 32. Registrar's Signature<br>   |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10





97 12674

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |                               |  |  |  |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
|--|-------------------------------|--|--|--|--|--|-------------------------------------|-----------------------------|--|-------------------------------------|------------------|------------|-------------------------------------|-------------------------------|--------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HAZEL MARGARET DAVIS</b>  |                               |  |  | 2. DATE OF DEATH<br>MONTH <b>Apr</b> DAY <b>11</b> , YEAR <b>1997</b>  |  | 3. TIME OF DEATH<br><b>7:20 PM</b>   |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 4. SOCIAL SECURITY NUMBER<br><b>214-62-4893</b>  |                               | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jun 20, 1909</b>  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>  |                               |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>DEVLIN MANOR NURSING HOME</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>   |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>   |                               |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Allegany</b>   |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>   |                               |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>613 Maryland Avenue</b>   |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 10f. ZIP CODE<br><b>21502</b>  |                               |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |                               |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>   |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |                               |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Nixon</b>   |                               |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jennie (nmn)</b>   |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Frank Davis, Jr.--son</b>   |                               |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>622 Maryland Avenue; Cumberland, MD 21502</b>  |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                               |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Davis Memorial Cemetery 04/14</b>  |  | 20c. LOCATION — City or Town, State<br><b>Cumberland, MD</b>   |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Nicholas J. Scarpelli</i>  |                               |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>   |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration Pneumonia</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><table border="1"> <tr> <td>a. DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Aspiration Pneumonia</b></td> <td>Approximate interval Between Onset and Death<br/><b>1 day</b></td> </tr> <tr> <td>b. DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Dysphagia</b></td> <td><b>6 m</b></td> </tr> <tr> <td>c. DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Organic Brain Syndrome</b></td> <td><b>3 yrs</b></td> </tr> </table> |                               |  |  |  |  |  | a. DUE TO (OR AS A CONSEQUENCE OF): | <b>Aspiration Pneumonia</b> | Approximate interval Between Onset and Death<br><b>1 day</b> | b. DUE TO (OR AS A CONSEQUENCE OF): | <b>Dysphagia</b> | <b>6 m</b> | c. DUE TO (OR AS A CONSEQUENCE OF): | <b>Organic Brain Syndrome</b> | <b>3 yrs</b> |
| a. DUE TO (OR AS A CONSEQUENCE OF):  | <b>Aspiration Pneumonia</b>   | Approximate interval Between Onset and Death<br><b>1 day</b>                   |  |  |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| b. DUE TO (OR AS A CONSEQUENCE OF):  | <b>Dysphagia</b>              | <b>6 m</b>   |  |  |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| c. DUE TO (OR AS A CONSEQUENCE OF):  | <b>Organic Brain Syndrome</b> | <b>3 yrs</b>   |  |  |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Recent aspiration; Chronic Coroner</b><br><b>Acute Ischemia</b>   |                               |  |  |  |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |                               |  |  |  |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |                               |  |  |  |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |                               |  |  |  |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |                               |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |                               |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |                               |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |                               |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John W. Bolling</i>  |                               |  |  | 29c. LICENSE NUMBER<br><b>D17565</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4-12-97</b>  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>A. J. Bolling MD 955 Frederick St Cumberland MD 21502</b>  |                               |  |  |  |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 15 1997</b>  |                               |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John W. Bolling</i>  |  |  |                                     |                             |  |                                     |                  |            |                                     |                               |              |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



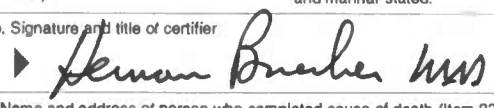
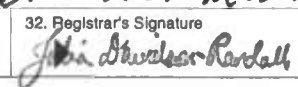
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12675

|   |   |  |  |  |  |   |   |   |  |
|---|---|--|--|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Eva Agnes Dudderar</b>                             |  |  |  | 2. Date of Death<br>Month Day Year<br><b>April 12 1997</b>   |   | 3. Time of Death<br><b>7:30 P.M.</b>                        |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Agnes Nursing Home</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Ellicott City</b> |   | 4c. County of Death<br><b>Howard</b>                        |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-03-5560</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.             |   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 9, 1908</b> |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                       |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Howard</b>                                 |   | 10c. City, Town or Location<br><b>Ellicott City</b>         |   |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3000 N. Ridge Road</b>  |  | 10f. Zip Code<br><b>21043</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                   |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurses Aid</b>   |  | 16b. Kind of Business/Industry<br><b>Seaton Institute</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Jesse Samuel Forney</b>                                     |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dennie Belle Schellar</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Borys Daughter</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17913 Marshall Mill Road Hampstead, MD 21074</b>   |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation</b>        |   | 20c. Location - City or Town, State<br><b>April 16, 1997 Hampstead, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Burrier-Queen Funeral Directors, P.A.<br/>1212 W. Old Liberty Road Winfield, MD 21784</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.<br><b>Pneumonia</b>  |  | Approximate Interval Between Onset and Death<br><b>4 days</b>   |   |   |  |
| Immediate Cause (Final disease or condition resulting in death)   |   | Due to (or as a consequence of):<br><b>CVA &amp; Aphasia, Hemiparesis (Multiple CVA's)</b>   |  | Due to (or as a consequence of):<br><b>Parkinson's Disease</b>   |  | Due to (or as a consequence of):<br><b>ASCVD</b>  |   | Years<br><b>Years</b><br><b>Years</b><br><b>Years</b>   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                              |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>DO 1317</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/14/97</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Herman Brecher M.D. 2337 N. Rolling Rd Baltimore Md 21244</b>  |   | 31. Date filed (Month, Day, Year)<br><b>APR 14 1997</b>  |  | 32. Registrar's Signature<br>   |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12676

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |                                |  |  |
|--|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Charles Edward Diebert, Jr.  |  |   |   | 2. Date of Death<br>Month Day Year<br>April 10 1997  |                                | 3. Time of Death<br>10:53am  |  |
| 4a. Facility Name (If not institution, give street and number)<br>12 S. Walnut Street #315   |  |   |   | 4b. City, Town, or Location of Death<br>Hagerstown   |                                | 4c. County of Death<br>Washington  |  |
| 5. Social Security Number<br>215-26-8248   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>79 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>June 4, 1917  |  |
| 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |   |  |                                |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Washington   |   | 10c. City, Town or Location<br>Hagerstown  |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br>12 S. Walnut Street #315   |  |   |   | 10f. Zip Code<br>21740   |                                | 10g. Citizen of What Country?<br>U.S.A.  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (14 or 5+) 0  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Door Shop Worker  |                                | 16b. Kind of Business/Industry<br>Lumber Company   |  |
| 17. Father's Name (First, Middle, Last)<br>Charles E. Diebert, Sr.   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bessie Mabel Beitler  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Ruth C. Diebert/Wife   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12 S. Walnut Street Hagerstown, Maryland 21740  |                                |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Manor Cemetery  |   | Date<br>4/14/97  |                                | 20c. Location - City or Town, State<br>Tilghmanton   |  |
| 21. Signature of Funeral Service Licensee<br>[Signature]   |  |   |   | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 E. Wilson Blvd. Hagerstown, Md. 21740  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Myocardial infarction<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   |  |                                |  | Approximate Interval Between Onset and Death<br>c 70 min   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>chronic obstructive pulmonary disease  |  |   |   |  |                                |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |                                |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>[Signature]  |   | 29c. License number<br>D00986  |                                | 29d. Date signed (Month, Day, Year)<br>04-14-97  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>max E. Bykit, M.D. 3 Bykit Drive Williamsport, md 21795  |  |   |   |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 15 1997   |  | 32. Registrar's Signature<br>[Signature]  |   |  |                                |  |  |

State  
Registrar

Abstracted by (95) 1 992

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12677

|  |   |  |   |   |  |   |  |  |   |  |
|--|---|--|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>KENNETH SUMAN DINSMORE</b>   |  |   |   | 2. Date of Death<br>Month <b>April</b> Day <b>7</b> Year <b>1997</b>   |   |  |  | 3. Time of Death<br><b>1:15 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>10200 Cascade Lane</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Largo</b>   |   |  |  | 4c. County of Death<br><b>Prince Georges</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-52-2272</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>July 22, 1941</b>                                    |  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>   |  |
|  | Usual Residence of Decedent   |  |   |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince Georges</b>   |  | 10c. City, Town or Location<br><b>Largo</b>   |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>10200 Cascade Lane</b>   |  | 10f. Zip Code<br><b>20774</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:    |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Technical Illustrator</b> |   | 16b. Kind of Business/Industry<br><b>Tech Publication</b>  |   |  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Benjamin Suman Dinsmore</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Grace Augusta Wenzel</b>   |   |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>John M. Moran-Friend</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10200 Cascade Lane, Largo, MD</b>  |   |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>                                      |   | Date<br><b>April 10, 1997</b>  |   | 20c. Location - City or Town, State<br><b>Suitland, MD</b>                                     |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br><b>Rendon/Hale Funeral Home</b><br><b>9013 Annapolis Road, Lanham, MD 20706</b>  |   |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Adrenal Carcinoma</b> |  |   |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>14 mos.</b>  |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anasarca 20 to Adrenal Cancer.</b>  |  |   |   |  |   |  |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br><b>M</b>                         |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                    |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   | 29b. Signature and title of certifier<br>               |  | 29c. License number<br><b>D31001</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/8/97</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stuart Turkewitz, M.D.</b>  |   |  |   | 31. Date filed (Month, Day, Year)<br><b>APR 09 1997</b> |  |   |  | 32. Registrar's Signature<br>                        |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12678

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Nema (First, Middle, Last)

BERNARD ANTHONY

DIVVER, SR.

2. Date of Death

April 3, 1997

3. Time of Death

7:40 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

11 South Carol Street

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Anne Arundel

5. Social Security Number

578-44-9834

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 18, 1935

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Laurel

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

11 South Carol Street

10f. Zip Code

20724

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Collector

16b. Kind of Business/Industry

Investment Company

17. Father's Nema (First, Middle, Last)

Arthur Jerome Divver

18. Mother's Nema (First, Middle, Maiden Sumama)

Lilla Wigginton

19a. Informant's Name/Relationship (Type, Print)

Bernard A. Divver (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 South Carol Street Laurel, MD 20724

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cemetery

Date

April 7, 1997

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Columbia Mortuary Services, Inc.  
9013 Annapolis Rd. Lanham, MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Right Lower Lobe Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Terminal Lung Cancer w/ metastasis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration, thrombocytopenia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Villamor S. Reyes MD

29c. License number

D29871

29d. Date signed (Month, Day, Year)

April 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Villamor Reyes, MD, 6501 Landover Road, Cheverly, MD 20785

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

John Michael Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



97 12679

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Nellie C. Davis  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 3, 1997   |  | 3. TIME OF DEATH<br>6:00 am  |  |
| 4. SOCIAL SECURITY NUMBER<br>577-28-2368   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>91 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 23, 1905                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1958 5th Street  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Owings   |  | 9c. COUNTY OF DEATH<br>Calvert   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Calvert  |  | 10c. CITY, TOWN OR LOCATION<br>Owings  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>1958 5th Street  |  |  |  | 10f. ZIP CODE<br>20736  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Supervisor  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Navy Ship Parts Control Center  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thomas Alexander Bolt Johnson   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Edith Annie Parker   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Jean E. Amster - Daughter  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1958 5th Street, Owings, Maryland 20736  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Forrest Oak Cemetery 04/06/97   |  | 20c. LOCATION — City or Town, State<br>Gaithersburg, Maryland   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Henry J. Ford</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Ave., Hyattsville, MD 20781   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  | Approximate Interval Between Onset and Death<br>1982 |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. Critical Aortic Stenosis<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  | 1982   |
|  |  | c. Coronary Artery Disease<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  | 1982   |
|  |  | d.   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Catherine Brophy, MD</i>   |  |  |  | 29c. LICENSE NUMBER<br>D45235   |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/4/97  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>19 E. Chesapeake Beach Road, Owings, MD 20736 (Catherine Brophy, MD)  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 07 1997   |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Anderson</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12680

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Ralph N. Davis</i>   |   | 2. Date of Death<br>Month <i>April</i> Day <i>8</i> Year <i>1997</i>   |   | 3. Time of Death<br><i>11:00 pm</i>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Southern Maryland Hospital</i>   |   | 4b. City, Town, or Location of Death<br><i>Clinton</i>   |   | 4c. County of Death<br><i>Prince George's</i>  |
| Funeral<br>Director  | 5. Social Security Number<br><i>416-32-1160</i>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>68</i> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><i>3/9/29</i>  | 9. Birthplace (State or Foreign Country)<br><i>Alabama</i>   |
|  | Usual Residence of Decedent   |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><i>Md.</i>  | 10b. County<br><i>P.G.</i>  | 10c. City, Town or Location<br><i>Deanwood Park</i>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><i>1125 Chapelwood Lane</i>   |   | 10f. Zip Code<br><i>20743</i>  |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>1951-1957 Korea</i> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Truck Driver</i>   |   | 16b. Kind of Business/Industry<br><i>Private Industry</i>  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Herbert Davis</i>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Carrie Riddle</i>  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Clyde Davis/Brother</i>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>5512 Hayes St., N.E., Wash., D.C. 20019</i>                          |   |  |
|  | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Cheltenham Vet's. Cem.,</i>   |   | 20c. Location - City or Town, State<br><i>Cheltenham, Md.</i>  |
|  | 21. Signature of Funeral Service Licensee<br><i>Dany H. Cratt</i>   |   | 22. Name and Address of Facility<br><i>H.S. Washington &amp; Sons, Inc.<br/>4925 Burroughs Ave., N.E.</i>  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Terminal Gall Bladder Cancer</i><br>Due to (or as a consequence of):<br><i>b. with Liver Metastases</i><br>Due to (or as a consequence of):<br><i>c.</i><br>Due to (or as a consequence of):<br><i>d.</i> |   | Approximate Interval Between Onset and Death<br><i>6 months</i>  |   |  |
|  | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  | 28b. Time of Injury<br><i>M</i>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>Dr. B. H. D. Attorneys</i>  |  | 29c. License number<br><i>S-24535</i>   | 29d. Date signed (Month, Day, Year)<br><i>4/9/97</i>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Laxmi N. Berwa, M.D. 7700 Old Branch Ave. #C-101, Clinton, Md. 20735</i>  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 11 1997</i>  |   | 32. Registrar's Signature<br><i>John H. H. H. H.</i>  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12681

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HAROLD E.

DONES

2. Date of Death

Month Day Year

March 30 97

3. Time of Death

4:15 PM

4a. Facility Name (If not institution, give street and number)

3211 South Leisure World Blvd.

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

180-14-8327

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 21, 1916

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10a. Street and Number

3211 South Leisure World Blvd.

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Caucasian

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Heating &amp; Plumbing

17. Father's Name (First, Middle, Last)

Raymond E. Jones

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Lewis

19a. Informant's Name/Relationship (Type, Print)

Luther Reid Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7013 Sulky Lane, Rockville, MD 20852

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)George Washington University Medical  
Center

Date

3/30/97

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Columbia Mortuary Services, Inc.  
225 Missouri Ave., NW, Washington, DC 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

Congestive Heart Failure

Approximate  
Interval Between  
Onset and Death

years.

Due to (or as a consequence of):

b.

Atherosclerotic Heart Disease

years.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Medical Examiner2 ☐ Certifying PhysicianTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

208546

29d. Date signed (Month, Day, Year)

March 30 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tauber

8218 Wisconsin Ave

Bethesda Md

31. Date filed (Month, Day, Year)

APR 02 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12682

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Francis De Neal

2. Date of Death

Month Day Year  
4 3 97

3. Time of Death

11:15pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health of Silver Spring

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-20-3938

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

5/1/03

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

901 Arcola Avenue

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Tradesman

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Robert De Neal

18. Mother's Name (First, Middle, Maiden Surname)

Annie Frances Smith

19a. Informant's Name/Relationship (Type, Print)

Doris Brown (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13100 Limetree Road, Silver Spring, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lincoln Memorial

Date

4/8/97

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

Alexander S. Pope, Jr.

22. Name and Address of Facility

Pope Funeral Homes  
11315 Lockwood Drive, Silver Spring, MD 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Failure

Sudden

Due to (or as a consequence of):

b. Pneumonia

Days

Due to (or as a consequence of):

c. Stroke

Months

Due to (or as a consequence of):

d. Atrial Fibrillation

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Suresh K. Gupta MD

29c. License number

D-32332

29d. Date signed (Month, Day, Year)

April 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh K. Gupta, MD 9801 Georgia Ave., #220 Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12683

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

RALPH DENNISON

2. Date of Death

APRIL 04 1997

3. Time of Death

1612

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

235-46-3257

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JUNE 22, 1930

9. Birthplace (State or Foreign Country)

West. Virginia

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

7420 WESTLAKE TERRACE

10f. Zip Code

20014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (14 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

JENNINGS DENNISON

18. Mother's Name (First, Middle, Maiden Surname)

SIBYL STEAD

19a. Informant's Name/Relationship (Type, Print)

RAY DENNISON/BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RT. 3 BOX 465 CLARKSBURG, W.VA. 26301

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARSHVILLE CEMETERY

Date

APRIL 8,

1997

20c. Location - City or Town, State

Marshville, W.Va.

21. Signature of Funeral Service Licensee

Paul L. Self

22. Name and Address of Facility

IVES-PEARSON FUNERAL HOMES

2847 WILSON BLVD. ARLINGTON, VA. 22201

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

ACUTE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE UNDEF.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis C. Mayhew

29c. License number

D07099

29d. Date signed (Month, Day, Year)

APRIL 4 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS C MAYHEW 10215 FERNWOOD RD BETHESDA MD 20817

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12684

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hugh Alexander Day, IV

2. Date of Death

April 6, 1997

3. Time of Death

11:05P.

4a. Facility Name (If not institution, give street and number)

4501 Ammendale Road

4b. City, Town, or Location of Death

Beltsville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

219-36-7728

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 5, 1940

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 Yes XX No

10e. Street and Number

4501 Ammendale Road

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

XX Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 2 No

If Yes, Give Year or Dates: 1959-1960

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes XX No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Hugh A Day, III

18. Mother's Name (First, Middle, Maiden Summa)

Louise Madeline Poff

19a. Informant's Name/Relationship (Type, Print)

Ronald E. Day (brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11905 Gordon Avenue Beltsville, Maryland 20705

20a. Method of Disposition

1 Burial 2 XX Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 4/7/1997

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Road Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c. Cardiorespiratory Arrest

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

December 1996

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3X Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes XX No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes XX No

25. Was case referred to medical examiner?

1 Yes 2X No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

5 Pending investigation

2 Accident

6 Could not be determined

3 Suicide

4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2X No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician

2 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Isabella Martire

29c. License number

D45014

29d. Date signed (Month, Day, Year)

April 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Isabella Martire, M.D. 8379 Cherry Lane Laurel, Maryland 20707

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

John Davidson-Pandell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12685

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Jennings Davis

2. Date of Death

Month Day Year  
April 7, 1997

3. Time of Death

5:10 P.M.

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-54-6411

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 22, 1915

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3420 Island Creek Court

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Hugh Jackson Jennings

18. Mother's Name (First, Middle, Maiden Surname)

Dollye Webb

19a. Informant's Name/Relationship (Type, Print)

Robert Linkous - Great Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12046 Greystone Drive, Monrovia, MD 21770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem.

Date

4/11/97

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Joseph Gawler's Sons, Inc.

5130 Wisconsin Avenue, NW, Washington, DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Arrest

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Cerebral Vascular Accident

Due to (or as a consequence of):

48 hours

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D33067

29d. Date signed (Month, Day, Year)

April 9th, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert Callino 106 Irving St New Wash DC 20010

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12686

## Certificate of Death

Reg. No.

|                                     |  |  |   |                                |  |
|-------------------------------------|--|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Christine O. Dailey</b>   |  | 2. Date of Death<br>Month Day Year<br><b>April 8, 1997</b>  |                                | 3. Time of Death<br><b>7:15A.</b>  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>  |                                | 4c. County of Death<br><b>Prince George's</b>  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>579-24-1733</b>  | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|                                     | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 28, 1919</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>   |                                |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent  |  |   |                                |  |
|                                     | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Prince George's</b>  | 10c. City, Town or Location<br><b>Accokeek</b>  |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|                                     | 10e. Street and Number<br><b>16724 Huron Street</b>  |  | 10f. Zip Code<br><b>20607</b>   |                                | 10g. Citizen of What Country?<br><b>United States</b>  |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |                                |  |
|                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |                                |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Thomas McGruder</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Suit Margaret Collier</b>   |                                |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shirley Lorraine Freeland (Daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13835 Burntwoods Rd. Glenelg, Maryland 21737</b>  |                                |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>George Washington Cemetery</b>   |                                | 20c. Location - City or Town, State<br><b>Adelphi, Maryland</b>  |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Donald V. Borgwardt</b>  |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>   |                                |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>LEUKEMIA</b><br>Due to (or as a consequence of):<br><b>Hemorrhage uncontrolled</b><br>Due to (or as a consequence of):<br><b>Diabetes</b><br>Due to (or as a consequence of):<br><b>ASHD</b>                 |  |   |                                | Approximate Interval Between Onset and Death<br><b>9 months</b>  |
|                                     | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |                                |  |
|                                     | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>  |
|                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |  |
|                                     | 29b. Signature and title of certifier<br><b>Michael D. Levine</b>  |  | 29c. License number<br><b>D 24945</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>April 8, 1997</b>  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael D. Levine, M.D. 1328 Southern Avenue, S.E. #301 Washington, D.C. 20032</b>  |  |   |                                |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>APR 11 1997</b>  |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



97 12687

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE HENRY DOUGLAS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>APRIL</b> DAY <b>16</b> , YEAR <b>1997</b>  |  | 3. TIME OF DEATH<br><b>9:45 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-38-3312</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>57</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUGUST 19, 1939</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>#6980 INDIAN HEAD HIGHWAY APT. #4</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BRYANS ROAD</b>  |  |
| 9c. COUNTY OF DEATH<br><b>CHARLES</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>CHARLES</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BRYANS ROAD</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>#6980 INDIAN HEAD HIGHWAY APT. #4</b>   |  |
| 10f. ZIP CODE<br><b>20616</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11TH GRADE</b><br>College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SHIPPING CLERK</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>TRANSPORTATION GIANT WAREHOUSE</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SIDNEY DOUGLAS</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>NANCY LOLA SAVOY DOUGLAS</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>BARBARA PINKNEY / DAUGHTER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>912 60TH AVENUE, CAPITAL HEIGHTS, MARYLAND 20743</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.)<br><b>TRINITY MEMORIAL GARDENS</b>   |  | 20c. LOCATION — City or Town, State<br><b>4/21/97 WALDORF, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>India C. Thornton Johnson</i><br><b>INDIA C. THORNTON JOHNSON M00583</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>THORNTON FUNERAL HOME, P.A.<br/>3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death: <b>years</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John A. Davis</i><br><b>John A. Davis</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>027389</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/17/97</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John A. Davis 1817 Waldorf, Md 20640</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 18 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Davis</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



97 12688

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNIE MILDRED DIETLE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>APR</b> DAY <b>14</b> YEAR <b>1997</b>   |  | 3. TIME OF DEATH<br><b>6:05 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>174-24-4905</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>OCT. 2, 1906</b>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GOODWILL MENNONITE HOME</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GRANTSVILLE</b>   |  | 9c. COUNTY OF DEATH<br><b>GARRETT Co.</b>   |  |
| 10a. STATE<br><b>PA</b>   |  |  |  | 10b. COUNTY<br><b>SOMERSET Co.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>MEYERSDALE</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>RD-3</b>   |  |   |  |
| 10f. ZIP CODE<br><b>15552</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOME</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HARVEY MILLER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BELINDA BAEK</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ELBERT MILLER</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RD-3 MEYERSDALE, PA. 15552</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GREENVILLE UNION CEME. 4-17-97</b>   |  | 20c. LOCATION — City or Town, State<br><b>RD-3 MEYERSDALE, PA</b>   |  | 20d. DATE<br><b>4-17-97</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>William L. Price</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>W. R. PRICE FUNERAL HOME, INC.<br/>325 MAIN ST. MEYERSDALE, PA 15552</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Coronary Artery Disease.</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Coronary Artery Disease.</b><br><b>Bronchitis.</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular Disease.</b><br><b>Bronchitis.</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicida<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James E. Bertel MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 34079</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>04-15-97</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James E. Bertel MD Grantsville MD 21536</b>   |  |  |  |   |  |   |  |
| 31. DATE Filled (Month, Day, Year)<br><b>APR 17 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Duckert</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12689

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Winn L. Eaton

2. Date of Death

Month 1 Day 3 Year 1997

3. Time of Death

21:57

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

578-09-5506

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6/24/07

9. Birthplace (State or Foreign Country)

Durham, N.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

312-B North Athol Ave.

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

1 Yr

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Chief-Supply Service

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

William Henry Eaton

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Lassiter

19a. Informant's Name/Relationship (Type, Print)

Ruth E. Freeman/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

508 25th Pl., N.E., Wash., D.C. 20002

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheltenham Vet's. Cem.

Date

4/8/97

20c. Location - City or Town, State

Cheltenham, Md.

21. Signature of Funeral Service Licensee

Dany M. Grate

22. Name and Address of Facility

H.S. Washington & Sons, Inc.  
4925 Burroughs Ave., N.E.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Organ Failure

Due to (or as a consequence of):

20 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Perforated Ulcer

Due to (or as a consequence of):

20 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin dependent Diabetes Mellitus

Alzheimer's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dany M. Grate

29c. License number

1992

29d. Date signed (Month, Day, Year)

April 3 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. C. Cerrone

St Agnes Hospital - Md.

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

John A. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12690

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |  |  |  |  |  |  |  |
|--|---|--|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>William Bryant Eaton, Sr.   |  |   |  | 2. Date of Death<br>Month Day Year<br>April 9, 1997   |  |  |  | 3. Time of Death<br>4:35 pm  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Hill Haven Nursing Center   |  |   |  | 4b. City, Town, or Location of Death<br>Adelphi   |  |  |  | 4c. County of Death<br>Prince George's   |  |  |  |
| Funeral<br>Director                              | 5. Social Security Number<br>577-09-5894  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>98 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 22, 1898                                 |  | 9. Birthplace (State or Foreign Country)<br>Mississippi  |  |  |  |
|  | Usual Residence of Decedent   |  |   |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director              | 10a. State<br>MD  |  | 10b. County<br>Prince George's  |  | 10c. City, Town or Location<br>Glenn Dale   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
|  | 10e. Street and Number<br>10000 Locust Street   |  |   |  | 10f. Zip Code<br>20769  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1921-22   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Engineer   |  |  | 16b. Kind of Business/Industry<br>Shipping<br>Marine Engineering |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Fred W. Eaton  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Beulah Batton  |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner    | 19a. Informant's Name/Relationship (Type, Print)<br>William B. Eaton, Jr. - Son   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10000 Lucust Street, Glenn Dale, Maryland 20769  |  |  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery   |  | 20c. Location - City or Town, State<br>Brentwood, Maryland                           |  | 20d. Date<br>04/14/97  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Cecil Lynn Gasch-Brady   |  |   |  | 22. Name and Address of Facility<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Avenue, Hyattsville, MD 20781   |  |  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ASPIRATION PNEUMONIA<br>Due to (or as a consequence of):<br>b. MULTIPLE STROKES<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br>2 WEEKS<br>SEVERAL YEARS |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |   |  |  |  |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |
| State Registrar                                  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br>Charles M Benner   |  |   |  | 29c. License number<br>D31563   |  | 29d. Date signed (Month, Day, Year)<br>April 10, 1997                                |  |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>CHARLES M BENNER MD, 11251 Lockwood Drive, Silver Spring, Maryland 20901  |  |   |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 11 1997 |   |  |   |  |   |  |  |  |  |  |  |  |
| 32. Registrar's Signature<br>John A. Russell     |   |  |   |  |   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12691

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Naomi L. Everett  |  |   |  | 2. Date of Death<br>Month Day Year<br>April 3, 1997  |  | 3. Time of Death<br>9:25 PM                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Manor Care Wheaton  |  |   |  | 4b. City, Town, or Location of Death<br>Wheaton  |  | 4c. County of Death<br>Montgomery                                |  |
| Funeral<br>Director   | 5. Social Security Number<br>265-74-0652  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>51 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 22, 1946             |  |
|   | 9. Birthplace (State or Foreign Country)<br>Texas   |  | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery  |  | 10c. City, Town or Location<br>Silver Spring                     |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>23 Lauer Court  |  | 10f. Zip Code<br>20901   |  | 10g. Citizen of What Country?<br>United States                   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Field Director                           |  | 16b. Kind of Business/Industry<br>Survey Research  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>John N. Lesko  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Evelyn K. Koemel  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Alexa Fraser  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4330 37th St., NW, Washington, DC 20016   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |  | 20c. Date<br>4-5- 97   |  | 20d. Location - City or Town, State<br>Beltsville, Maryland      |  |
|   | 21. Signature of Funeral Service Licensee<br>Ellen H. Rapp  |  |   |  | 22. Name and Address of Facility<br>Rapp Funeral Services, P. A.<br>933 Gist Avenue, Silver Spring, MD 20910   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ARRHYTHMIA<br>Due to (or as a consequence of):<br>b. CARCINOMA STOMACH<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
|   | Approximate Interval Between Onset and Death<br>10 MINUTES  |  |   |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|   |   | 28d. Describe how injury occurred      |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>T. J. Anthony, MD  |   |  |   | 29c. License number<br>D 50300   |  | 29d. Date signed (Month, Day, Year)<br>APRIL 4, 1997                                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>THOMAS J ANTHONY, MD 11119 ROCKVILLE PIKE, #316, ROCKVILLE MD 20852   |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 07 1997  |   |  |   | 32. Registrar's Signature<br>Julia Davidson-Rendall                                    |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

20

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12692

## Certificate of Death

Reg. No.

|  |   |   |   |                                |   |  |  |  |  |
|--|---|---|---|--------------------------------|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>SALLYE RENEE ERLACH   |   |   |                                | 2. Date of Death<br>Month Day Year<br>APRIL 17, 1997  |  | 3. Time of Death<br>5:54 AM                                      |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>PHYSICIANS MEMORIAL HOSPITAL  |   |   |                                | 4b. City, Town, or Location of Death<br>LAPLATA   |  | 4c. County of Death<br>CHARLES                                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>223-16-0162  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>90 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  | 6. Date of Birth (Month, Day, Year)<br>Jan. 30, 1907                                 |  | 9. Birthplace (State or Foreign Country)<br>Virginia |  |
|  | Usual Residence of Decedent   |   |   |                                | 10a. State<br>MD  |  | 10b. County<br>Charles   |  | 10c. City, Town or Location<br>Indian Head |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |                                | 10e. Street and Number<br>147 Circle Avenue   |  | 10f. Zip Code<br>20640   |  | 10g. Citizen of What Country?<br>U.S.A.    |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife                                |                                | 16b. Kind of Business/Industry<br>Home  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>John James DaPrato   |   |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mildred Rena Seal  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Cherly E. Reese   |   |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 460 Bryans Road Maryland 20616  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Trinity Memorial  |                                | 20c. Location - City or Town, State<br>4-21-97 Waldorf, MD  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>David C. Echols MO0945   |   |   |                                | 22. Name and Address of Facility<br>Arehart-Echols Funeral Home P.O. Box 567 La Plata, MD 20646   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CARCINOMATOSIS<br>Due to (or as a consequence of):<br>b. LUNG CANCER<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>370<br>172 |   |   |                                |   |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |                                |   |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |                                |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>LIVER METASTASIS<br>LEUKOPENIA   |   |   |   |                                |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of injury<br>M       |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>Joel Seuchand  |   | 29c. License number<br>D-29646 |   | 29d. Date signed (Month, Day, Year)<br>04, 17, 97                                    |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JOEL SEUCHAND M.D. MEDICAL ARTS CENTER 3600 LEONARDTOWN ROAD #103 WALDORF MD. 20601  |   |   |   |                                |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 18 1997   |   | 32. Registrar's Signature<br>John Davidson Randall  |   |                                |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12693

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|--|--|---|---|---|--|--|---|--|---|--------------------------------------|--|----------------------------------|--|------------------------|--------------|----------------------------------|--|---|---------------|------------------|----------------------------------|--|----|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>RAYMOND GILBERT EVERETT SR.</b>   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 14 1997</b>   |  | 3. Time of Death<br><b>7:21 PM</b>                                      |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL &amp; MEDICAL CENTER</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |  | 4c. County of Death<br><b>ALLEGANY</b>                                  |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-26-7164</b>  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>July 4, 1930</b>  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | Usual Residence of Decedent  |   |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
| To Be Completed by Funeral Director  | 10a. State<br><b>PA</b>  | 10b. County<br><b>Bedford</b>   | 10c. City, Town or Location<br><b>Hyndman</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | 10e. Street and Number<br><b>RD 1</b>  |   |   | 10f. Zip Code<br><b>15545</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   | 16e. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Painter</b>                        |   | 16b. Kind of Business/Industry<br><b>Painting</b>  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | 17. Father's Name (First, Middle, Last)<br><b>Gilbert F. Everett</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lola (Stump)</b>  |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Barbara Coppinger--daughter</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>142 Tuttle Street; Fall River, MA 02724</b> |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | 20e. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cumberland Crematory</b>   |   | Date<br><b>04/16</b>   |  | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>            |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>  |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Intra-Abdominal Hemorrhage</b></td> <td>Approximate Interval Between Onset and Death<br/><b>Six Hours</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>Hypertension</b></td> <td><b>Years</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="3">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. <b>CVA</b></td> <td><b>Five Days</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">d.</td> </tr> </table> |   |   |   |  |  |   |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Intra-Abdominal Hemorrhage</b> | Approximate Interval Between Onset and Death<br><b>Six Hours</b> | Due to (or as a consequence of): |  | b. <b>Hypertension</b> | <b>Years</b> | Due to (or as a consequence of): |  | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. <b>CVA</b> | <b>Five Days</b> | Due to (or as a consequence of): |  | d. |
| Immediate Cause (Final disease or condition resulting in death)  | a. <b>Intra-Abdominal Hemorrhage</b>   | Approximate Interval Between Onset and Death<br><b>Six Hours</b>  |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | Due to (or as a consequence of):   |   |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | b. <b>Hypertension</b>   | <b>Years</b>  |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | Due to (or as a consequence of):   |   |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | c. <b>CVA</b>  | <b>Five Days</b>  |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | Due to (or as a consequence of):   |   |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  | d.   |   |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  |  |   |   |   |  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
| 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br><b>D 46346</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>04/16/97</b>   |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>HUMA SHAKIL M.D., 625 KENT AVE., CUMBERLAND, MD 21502</b>   |  |   |   |   |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |
| 31. Date filed (Month, Day, Year)<br><b>APR 17 1997</b>  |  |   |   | 32. Registrar's Signature<br>                                |  |  |   |  |   |                                      |  |                                  |  |                        |              |                                  |  |   |               |                  |                                  |  |    |

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12694

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Dion Lamont Ford

2. Date of Death

Month Day Year

4 6 97

3. Time of Death

1715h

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

5. Social Security Number

579-92-8704

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

3/18/62

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Palmer Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7733 Burnside Road

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Donald Ford

18. Mother's Name (First, Middle, Maiden Surname)

Denise Wilkinson

19a. Informant's Name/Relationship (Type, Print)

Donald Ford - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2001 Ridge Crest Crt. SE Apt. #204 Washington DC 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Date

4/12/97

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Philip Sue

22. Name and Address of Facility

Robert G. Mason Funeral Home

1661 Good Hope Rd. SE Washington, DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

Due to (or as a consequence of):

b. Cardio respiratory Arrest

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

9 mo +

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

A. Clark Holmes, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12695

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID FEASTER

2. Date of Death

Month Day Year  
APRIL 02 1997

3. Time of Death

10:45pm

4a. Facility Name (If not institution, give street and number)

310 BEREK ST

4b. City, Town, or Location of Death

LARGO

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

237-54-9135

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 22, 1938

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

310 DEREK STREET

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Marriad 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

RESEARCH ASSISTANT

16b. Kind of Business/Industry

(FED. GOVT.)

DEPT. OF AGRICULTURE

17. Father's Name (First, Middle, Last)

WADDELL FEASTER

18. Mother's Name (First, Middle, Maiden Sumama)

NANCY GUNTER

19a. Informant's Name/Relationship (Type, Print)

GERALDINE FEASTER/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

310 DEREK ST. UPPER MARLBORO, MARYLAND 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

4-7-97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

Quawara L. Braxton

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME OF MD  
4308 SUITLAND RD. SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mario F. Golve Jr MD

29c. License number

DEPUTY MEDICAL EXAMINER  
D 33954

29d. Date signed (Month, Day, Year)

APRIL 06, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLVE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State  
Registrar

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

John A. ...

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



97 12696

-1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BERTHA MAYE FREYMAN</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APR 12 1997</b>  |  | 3. TIME OF DEATH<br><b>6:10P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-32-9811</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>DEC 2 1911</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GLEN BURNIE, MD</b>   |  | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>  |  |
| 10a. STATE<br><b>MD</b>  |  |   |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>SEVERNA PARK</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>573 WEST DR</b>   |  |   |  | 10f. ZIP CODE<br><b>21146</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 8+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN A. S. MAUN</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BERTHA M. RIDER</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>BERTHA E. CHOWANETZ</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1201 PURNELL RD, S. PARK, MD 21146</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GREEN HILL CEMETERY</b>   |  | DATE<br><b>4/15</b>   |  | 20c. LOCATION — City or Town, State<br><b>WAYNESBORO, PA</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>JAMES A. BOWERSOX</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>GROVE FUNERAL HOME, INC<br/>50 S BROAD ST WAYNESBORO PA 17268</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>DILATED IDIOPATHIC CARDIOMYOPATHY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>CARDIOGENICK SHOCK</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>CAROTID ARTERY STENOSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b></b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>5 YRS</b><br><b>2 DAYS</b><br><b>2 DAYS</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>P 47689</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APR 12 1997</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>APPIAH-PIPPIM N ARUNDEL HOSP. 301 HOSPITAL DR, GLEN BURNIE, MD 21061</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 15 1997</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12697

## Certificate of Death

Reg. No.

|  |  |  |  |  |   |  |                                |  |   |  |  |
|--|--|--|--|--|---|--|--------------------------------|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Avis L. R. Foote   |  |  |  | 2. Date of Death<br>Month Day Year<br>April 10, 1997  |  |                                |  | 3. Time of Death<br>12:30 P.M.  |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital  |  |  |  | 4b. City, Town, or Location of Death<br>Silver Spring   |  |                                |  | 4c. County of Death<br>Montgomery   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-62-9805   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>39 Yrs.   |  | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.  |  |  |
|  | 8. Date of Birth (Month, Day, Year)<br>July 31, 1957   |  | 9. Birthplace (State or Foreign Country)<br>Washington, D.C.                   |  | Usual Residence of Decedent   |  | 10a. State<br>Maryland         |  | 10b. County<br>Prince George's  |  |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br>Upper Marlboro  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                |  | 10e. Street and Number<br>13112 Whiteholm Drive   |  |  |
|  | 10f. Zip Code<br>20774   |  |  |  | 10g. Citizen of What Country?<br>USA  |  |                                |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |
|  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Statistician   |  |                                |  | 16b. Kind of Business/Industry<br>Federal Government  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Leslie Hamilton Reid  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Phyllis Holland  |  |                                |  | 19a. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3360 Ponds Wood Road Huntingtown, MD 20639   |  |  |
|  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3360 Ponds Wood Road Huntingtown, MD 20639  |  |  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Plum Point UMC Cemetery   |  |  |
|  | 20c. Location - City or Town, State<br>Huntingtown, MD   |  |  |  | 21. Signature of Funeral Service Licensee<br>Spencer E. Sewell  |  |                                |  | 22. Name and Address of Facility<br>Sewell Funeral Home<br>1451 Dares Beach Rd. Prince Frederick, MD 20678  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Cerebral bleed<br>Due to (or as a consequence of):<br>b. Septic emboli<br>Due to (or as a consequence of):<br>c. Coagulopathy due to end stage liver disease + sepsis<br>Due to (or as a consequence of):<br>d. Cryptogenic atherosclerosis - end stage with atherosclerosis, Bacterial endocarditis + sepsis |  |  |  | Approximate Interval Between Onset and Death  |  |                                |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |
|  | 23c. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 23d. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                                |  | 24. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |  |
| 28a. Date of Injury (Month, Day Year)  |  |  |  | 28b. Time of Injury<br>M   |   |  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |  |
| 28d. Describe how injury occurred  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br>Spencer E. Sewell M.D.  |   |  |                                | 29c. License number<br>D40395  |   |  |  |
| 29d. Date signed (Month, Day, Year)<br>4/11/97   |  |  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Karen Handover Center, 8300 Corporate Dr. Landover, MD 20785 |   |  |                                | 31. Date filed (Month, Day, Year)<br>APR 14 1997                                     |   |  |  |
| 32. Registrar's Signature<br>John Andrew Randall   |  |  |  |  |   |  |                                |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12698

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

2. Date of Death

3. Time of Death

5. Social Security Number

6. Sex

7. Age (In yrs. last birthday)

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

10e. Street and Number

10f. Zip Code

10g. Citizen of What Country?

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black, White, etc.

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:1 ☐ Yes 2 ☒ No Specify:

Specify: White

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

College (1-4 or 5+)

Sales Representative

Textile Co.

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mrs. Cathy Grant (Trustee)

CCB&amp;T 45 W. Main Street, Westminster, MD 21157

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

Woodlawn Cemetery

4/17/97 Canandaigua, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HAIGHT FUNERAL HOME &amp; CHAPEL (Box 195)

Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Respiratory arrest*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. *Aspiration pneumonia*  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 12699

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virle Ileene Ferguson

2. Date of Death

April 7, 1997

3. Time of Death

2:48 AM

4a. Facility Name (If not institution, give street and number)

9100 Wooden Bridge Road

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

495-03-7758

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

April 18, 1914

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9100 Wooden Bridge Road

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Executive Assistant

18b. Kind of Business/Industry

Greeting Cards

17. Father's Name (First, Middle, Last)

Allan McDonald

18. Mother's Name (First, Middle, Maiden Surname)

Willa Cummings

19a. Informant's Name/Relationship (Type, Print)

Albert Kenneth Ferguson/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9100 Wooden Bridge Road, Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

Date

April 11, 1997

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Barbara Jo McMullen Lawrence

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Avenue, Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Pancreatic Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 1/2 months

Sequitally list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

George A. Sotos

29c. License number

D43083

29d. Date signed (Month, Day, Year)

April 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George A. Sotos, M.D. 9707 Medical Center Drive, #300, Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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within 24 hours after death.  
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12700

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |   |   |  |  |
|---|--|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Judith Marie Flannery</b>   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>April 2, 1997</b>   |   | 3. Time of Death<br><b>11:10 am</b>                                     |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>River &amp; Montevideo Roads</b>  |   |  |  | 4b. City, Town, or Location of Death<br><b>Potomac</b>   |   | 4c. County of Death<br><b>Montgomery</b>                                |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>141-32-3997</b>  | 6. Sex<br><b>1 M 2 F</b>                                      | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec 24, 1939</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Delaware</b>  |  |
|   | Usual Residence of Decedent  |   |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Montgomery</b>                              |  | 10c. City, Town or Location<br><b>Chevy Chase</b>  |  |   | 10d. Inside City Limits<br><b>1 X Yes 2 No</b>                          |  |  |
|   | 10e. Street and Number<br><b>4103 Woodbine Street</b>  |   |  | 10f. Zip Code<br><b>20815</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>              |   |  |  |
|   | 11. Marital Status<br><b>1 X Navar Married 2 X Married</b><br><b>3 Widowed 4 Divorced</b>  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b><br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b> Specify:       |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker &amp; Triathlete</b> |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>           |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Adam Sysko</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Sheehan</b>   |   |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dennis M. Flannery- Husband</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4103 Woodbine St., Chevy Chase, MD 20815</b> |   |   |  |  |
|   | 20a. Method of Disposition<br><b>1 X Burial 2 Cremation 3 Removal from State</b><br><b>4 Donation 5 Other (Specify)</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>                                       |  | Date<br><b>4/7/97</b>  |   | 20c. Location - City or Town, State<br><b>Silver Spring, Md</b>         |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |  |  | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons Inc.,</b><br><b>5130 Wisconsin Ave., N.W. Washington DC 20016</b>                    |   |   |  |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Multiple Injuries</b> |   |  |  |  |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 X No 3 Probably 4 Unknown</b>   |   |  |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><b>1 X Yes 2 No</b>   |  |   |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 X Yes 2 No</b>   |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  |   |  |  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify) SCENE</b> |  |
| 27. Manner of Death<br><b>1 Natural 2 X Accident 3 Suicide 4 Homicide</b><br><b>5 Pending Investigation 6 Could not be determined</b>   |  | 28a. Date of Injury (Month, Day, Year)<br><b>Apr. 2, 1997</b> |  | 28b. Time of Injury<br><b>11:00A M</b>   |  | 28c. Injury at Work?<br><b>1 Yes 2 X No</b>                 |   | 28d. Describe how injury occurred<br><b>Bicyclist struck by auto</b>   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>River &amp; Montevideo Rds.</b> |  |   |   |  |  |
| 29a. Certifier<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> |  |   |  |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><br><b>O. C. M. E.</b>  |  |   |  | 29c. License number  |  | 29d. Date signed (Month, Day, Year)<br><b>April 3, 1997</b> |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Laron Locke, MD 111 Penn Street, Baltimore, Md 21201</b>  |  |   |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 09 1997</b>   |  |   |  | 32. Registrar's Signature<br>   |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12701

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline A. Feldman

2. Date of Death

Month  
4Day  
2Year  
1997

3. Time of Death

3:35 P.M.

4a. Facility Name (If not Institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-24-9476

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

November 28, 1909

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5901 Montrose Road, South 408

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry

Law Firm

17. Father's Name (First, Middle, Last)

Max Aein

18. Mother's Name (First, Middle, Maiden Surname)

Celia Nathanson

19a. Informant's Name/Relationship (Type, Print)

Michele Friedman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4600 Stoneleigh Court, Rockville, MD 20852

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

4-5-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P.A.  
933 Gist Avenue, Silver Spring, Maryland 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

b. PNEUMONIA

Due to (or as a consequence of):

c. SEPSIS

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Maya H. Helt Thompson

29c. License number

D 446025

29d. Date signed (Month, Day, Year)

4/4/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

THOMPSON, M. LINDA M. 11125 Rockville Pike, #123  
Rockville, MD 20852

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12702

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES

GRIER

2. Date of Death

Month Day Year  
APRIL 8, 1997

3. Time of Death

08:46 P.M.

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death

CAMP SPRINGS

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

252-32-7965

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT. 16, 1921

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

CAPITOL HEIGHTS

10d. Inside City Limits

Yes ☒ No ☐

10e. Street and Number

6814 HASTINGS DRIVE

10f. Zip Code

20743

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

NO

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12TH

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

ARTHUR

BOWMAN

18. Mother's Name (First, Middle, Maiden Surname)

LILLIE THOMAS

BOWMAN

19a. Informant's Name/Relationship (Type, Print)

LaTONYA Y. MORRISEY/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6814 HASTINGS DRIVE, CAPITOL HEIGHTS, MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON NATIONAL CEM.

Date

04-16-97

20c. Location - City or Town, State

ARLINGTON, VA

21. Signature of Funeral Service Licensee

EDWARD M. DUDLEY

22. Name and Address of Facility

DUDLEY FUNERAL HOME

3200 R.I. AVE., MT. RAINIER, MARYLAND 20712

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIORESPIRATORY ARREST

45 MIN

Due to (or as a consequence of):

b. ASPIRATION

MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

4301406999 MI

29d. Date signed (Month, Day, Year)

APRIL 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES ORTMEYER, MAJ, USAF, MC

89 MDG/1050 W PERIMETER RD SUITE C1-7

ANDREWS AIR FORCE BASE, MD 20762-6600

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

John A. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12703

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pearl Harris Gregory

2. Date of Death

Month Day Year  
April 7 1997

3. Time of Death

8:20 AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

234-36-1393

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 23, 1925

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6100 Westchester Park Drive #1017

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Account Executive

16b. Kind of Business/Industry

Advertising

17. Father's Name (First, Middle, Last)

Paul G. Harris

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Kent Snead

19a. Informant's Name/Relationship (Type, Print)

Floyd Gregory - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6100 Westchester Park Drive #1017, College Park, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

G. Washington Cemetery

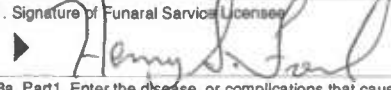
Date

4/4/97

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *Respiratory failure*

Due to (or as a consequence of):

9 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *End stage diffuse pulmonary fibrosis*

Due to (or as a consequence of):

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Pneumonia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

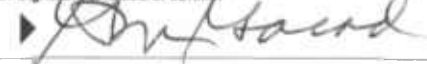
28a. Date of Injury

(Month, Day, Year)  
*N/A*28b. Time of  
Injury*N/A*28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

*N/A*28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D17799

29d. Date signed (Month, Day, Year)

4/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GERARDO M GARCIA MD 6510 Kemelworth Av Riverdale MD 20737

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

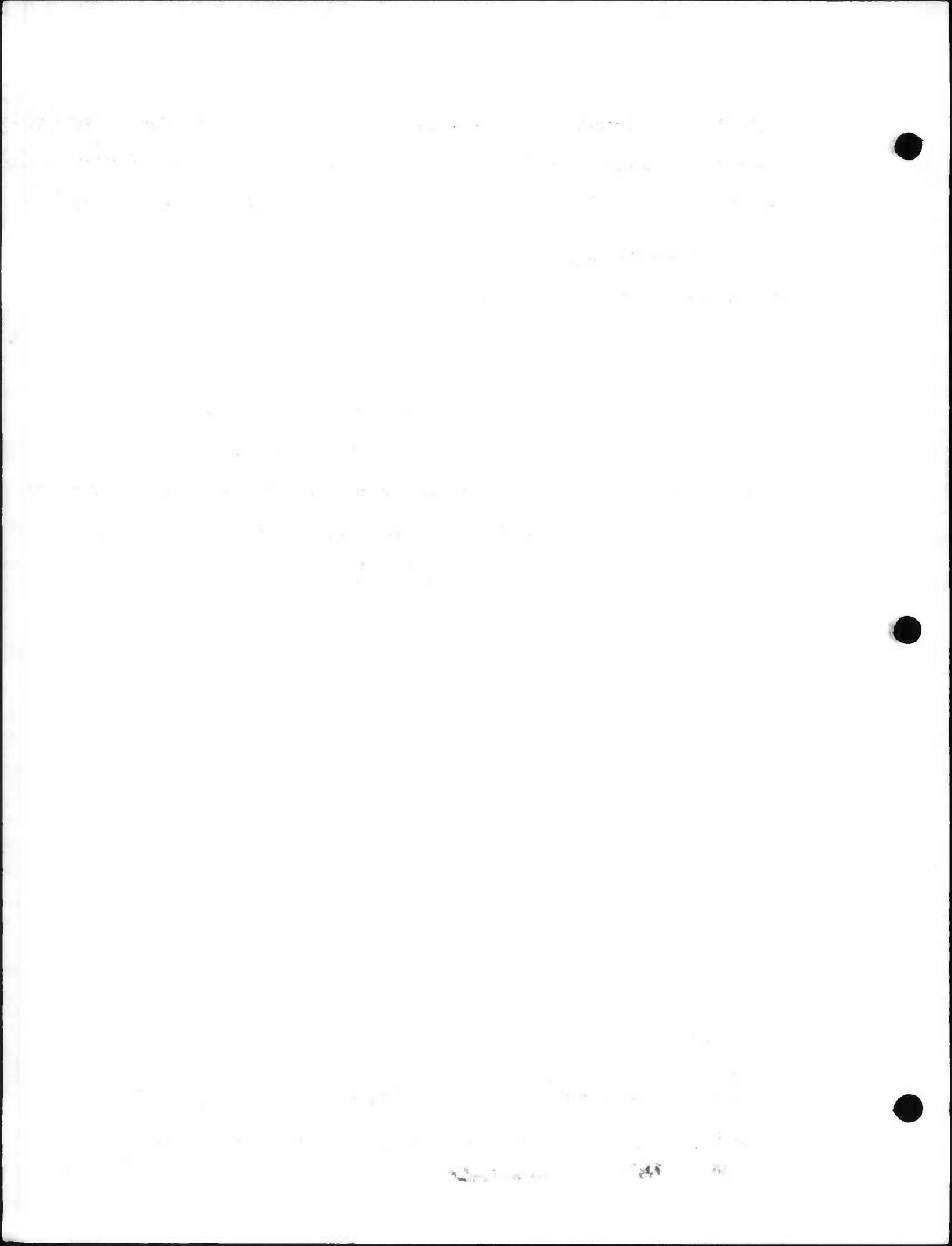
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12704

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GWENDOLYN

GRAY

2. Date of Death

Month

Day

Year

APRIL

3

1997

3. Time of Death

14:20 PM

4a. Facility Name (If not institution, give street and number)

SOUTHEAN

MARYLAND

HOSPITAL

4b. City, Town, or Location of Death

CHINTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

243-28-2391

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

10/10/22

Year

9. Birthplace (State or Foreign)

HIGHTPOINT, NC

Usual Residence of Decedent

10a. State

DC

10b. County

N/A

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5044 SARGENT ROAD NE

10f. Zip Code

20017

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (1-4 or 5+)

4 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life)

GOVERNMENT EMPLOYEE

16b. Kind of Business/Industry

RECORD CATALOGER/LIB OF CONGRESS GOVERNMENTAL

17. Father's Name (First, Middle, Last)

SHEPARD STRUDWYCK WHITTED

18. Mother's Name (First, Middle, Maiden Surname)

BLANCH WILSON

19a. Informant's Name/Relationship (Type, Print)

ROSCOE L. GRAY, JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS 10A, B, C, D, E, &amp; F

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT LINCOLN CEMETERY

Date

4/8/97

20c. Location - City or Town, State

BRENTWOOD, MD.

21. Signature of Funeral Service Licensee

Robert L. P...

22. Name and Address of Facility

JOHN T. RHINES CO., INC.

3030 12TH ST NE, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR

Due to (or as a consequence of):

DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GASTROINTESTINAL BLEEDING

PNEUMONIA

UNDOSEPTIC

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Philip Wisotzky MD

29c. License number

D-18545

29d. Date signed (Month, Day, Year)

APRIL 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHILIP WISOTZKY MD

700 OLD LINE CENTRE WALDOF MD 20602

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

John A. ...

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12705

## Certificate of Death

Reg. No.

|  |  |  |   |                               |  |  |  |  |
|--|--|--|---|-------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>BOYD SCOTT GODLOVE JR.   |  |   |                               | 2. Date of Death<br>Month Day Year<br>April 13 1997  |  | 3. Time of Death<br>9:10 pm  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital   |  |   |                               | 4b. City, Town, or Location of Death<br>Hagerstown   |  | 4c. County of Death<br>Washington  |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-14-9252   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |                               | 7. Age (In yrs. last birthday)<br>72 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>May 13, 1924                                  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>Maryland  |                               | 10b. County<br>Washington  |  | 10c. City, Town or Location<br>Hagerstown  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>853 Summit Avenue   |                               | 10f. Zip Code<br>21740   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (14 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Foreman                                  |                               | 16b. Kind of Business/Industry<br>Steel Fabrication  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Boyd Scott Godlove Sr.  |  |   |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Helen Leota Dorsey  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Nancy G. Ebersole  |  |   |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>320 River Drive, York Haven, Pennsylvania 17370   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery 04-16-97  |                               | 20c. Location - City or Town, State<br>Hagerstown, Maryland  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>R. Noel Brady   |  |   |                               | 22. Name and Address of Facility<br>Andrew K. Coffman Funeral Home, Inc.<br>40 East Antietam Street, Hagerstown, Md. 21740   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>Cardiac Arrest<br>Due to (or as a consequence of):<br>Coronary Atherosclerosis<br>Due to (or as a consequence of):<br>Coronary Vascular Disease<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>c. d. |  |   |                               |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |                               |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |                               |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |                               |  |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |  |   |                               |  |  |  |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |                               | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred  |  |   |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |                               |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |                               |  |  |  |  |
| 29b. Signature and title of certifier<br>Martin G. Ballenger MD  |  |  |   | 29c. License number<br>D31880 |  | 29d. Date signed (Month, Day, Year)<br>4/14/97 |  |  |
| 30. Name and address of person who completed cause of death (Item 30e) (Type, Print)<br>Martin G. Ballenger MD 1110 Medical Campus Rd, Hagerstown  |  |  |   |                               |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 17 1997   |  |  |   |                               |  |  |  |  |
| 32. Registrar's Signature<br>John D. ...   |  |  |   |                               |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

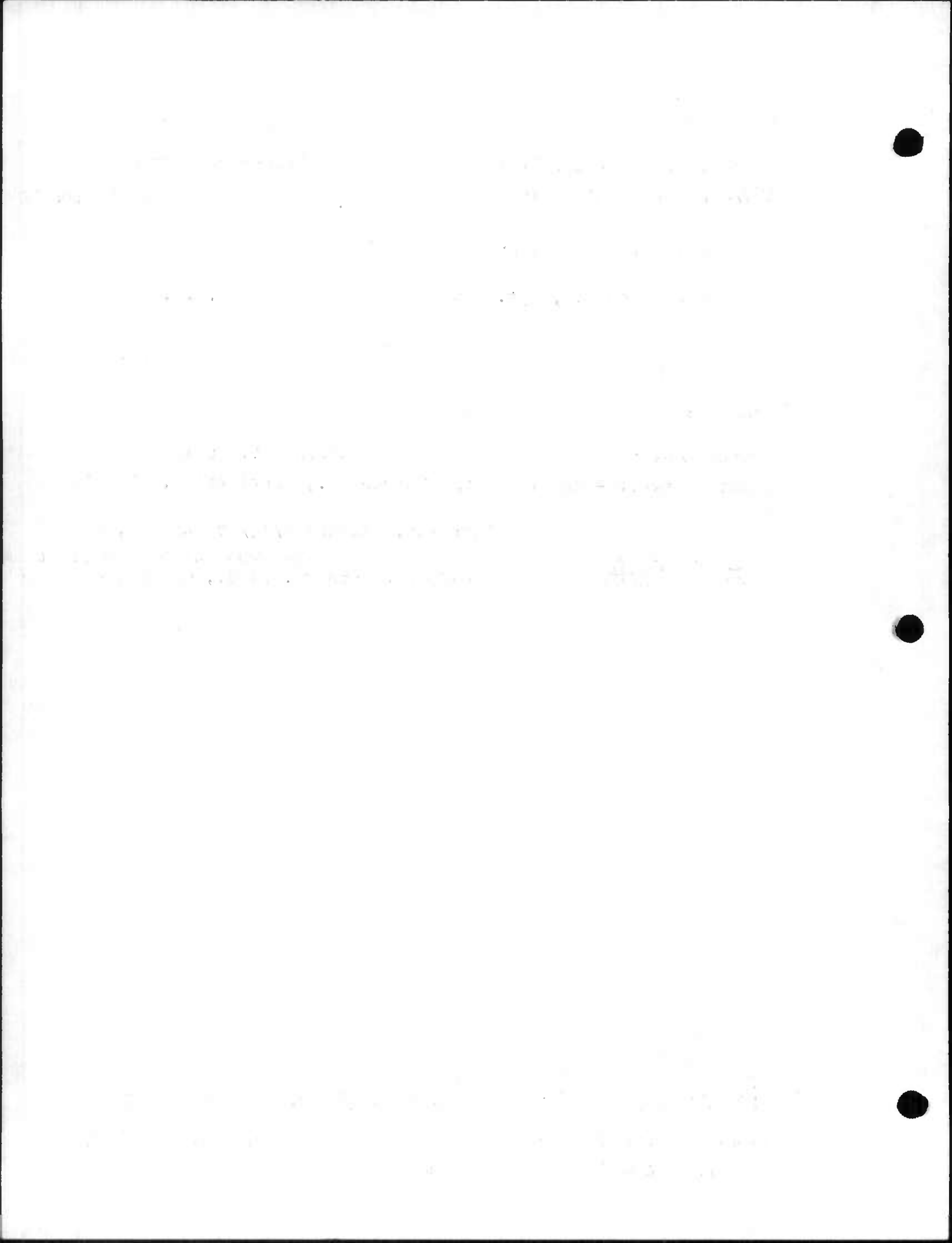
97 12706

|   |  |                               |   |  |  |                                 |  |  |  |  |  |
|---|--|-------------------------------|---|--|--|---------------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Helen Louise Gunsaulley</b>                         |                               |   |  | 2. Date of Death<br>Month Day Year<br><b>April 10, 1997</b>  |                                 |  |  | 3. Time of Death<br><b>2318</b>                                  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b> |                               |   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick Calvert</b>  |                                 |  |  | 4c. County of Death  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577/20/6546</b>  |                               | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>May 5, 1920</b>                                      |  | 9. Birthplace (State or Foreign Country)<br><b>Washington DC</b> |  |  |
|   | Usual Residence of Decedent  |                               |   |  | 10c. City, Town or Location  |                                 | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  |
| 10e. State<br><b>MD</b>   |  | 10b. County<br><b>Calvert</b> |   | 10f. Zip Code<br><b>20678</b>  |  |                                 |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |  |  |  |
| 10e. Street and Number<br><b>250 Shore Acres Way, Apt. 140</b>  |  |                               |   | 10f. Zip Code<br><b>20678</b>  |  |                                 |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 12</b> College (1-4 or 5+)  |  |                               |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  |                                 |  | 16b. Kind of Business/Industry<br><b>Homemaker</b>                               |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Arthur Easton</b>   |  |                               |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence V. Smith</b>  |  |                                 |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Janet Holsworth-Daughter</b>   |  |                               |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5620 Warren Dr., Huntingtown, MD 20639</b>   |  |                                 |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                               |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Southern Mem. Gardens</b>   |  |                                 |  | 20c. Location - City or Town, State<br><b>4/14/97 Dunkirk, MD</b>                |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>St. E. Smith</b>  |  |                               |   | 22. Name and Address of Facility<br><b>Lee Funeral Home Calvert PA<br/>8125 Southern MD. Blvd., Owings, MD 20736</b>   |  |                                 |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>CVA</b><br>Due to (or as a consequence of):<br>b. <b>dehydration</b><br>Due to (or as a consequence of):<br>c. <b>acute abdominal catastrophe</b><br>Due to (or as a consequence of):<br>d. <b>Inverticulus</b> |  |                               |   |  |  |                                 |  |  |  | Approximate Interval Between Onset and Death<br><b>Unknown</b><br><b>Unknown</b><br><b>Unknown</b><br><b>Unknown</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                               |   |  |  |                                 |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   |  |                               |   |  |  |                                 |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  |                               |   |  |  |                                 |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                               |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |                               |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                               |   | 29b. Signature and title of certifier<br><b>Kiourmarce Yazdani MD</b>  |  |                                 |  | 29c. License number<br><b>D17168 MD</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4-11-97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kiourmarce Yazdani, MD, PO Box 70, Huntingtown, MD 20639</b>   |  |                               |   |  |  |                                 |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1997</b>   |  |                               |   | 32. Registrar's Signature<br><b>J. Davidson-Randall</b>  |  |                                 |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12707

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alita Elizabeth Griffin

2. Date of Death

Month Day Year  
April 5, 1997

3. Time of Death

8:09 AM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

082-62-5691

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

32 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 8, 1965

9. Birthplace (State or Foreign Country)

Thailand

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1206 Peachwood Lane

10f. Zip Code

20716

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Donald R. Griffin, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Althea Howard

19a. Informant's Name/Relationship (Type, Print)

Donald R. Griffin, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

4-8-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P. A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Cardiomyopathy*

Due to (or as a consequence of):

b. *systemic Lupus Erythematosus*

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastc. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*End Stage Renal Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Juan P. Bosch

29c. License number

15315

29d. Date signed (Month, Day, Year)

April 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Juan P. Bosch, M.D.

2150 Pennsylvania Avenue, NW, #4-425, Washington, DC 20037-2396

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12708

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Goldie Abrams Gordon

2. Date of Death

Month

Day

Year

April

7

1997

3. Time of Death

1:00AM

4a. Facility Name (If not institution, give street and number)

4550 N. Park Avenue

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578 10 2969

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct 31, 1917

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4550 N. Park Avenue

10f. Zip Code

20815

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry Abrams

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Glenn

19a. Informant's Name/Relationship (Type, Print)

Patricia G. Kleinman Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4550 N. Park Avenue Chevy Chase, MD 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King David Memorial Park 4/08/97 Falls Church, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives Pearson Funeral Home

472 N. Washington St Falls Church VA 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Metastatic Kidney Cancer

Approximate  
Interval Between  
Onset and Death

months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28e. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D1504C

29d. Date signed (Month, Day, Year)

April 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN J NEWMAN 1926 Montgomery Village Ave Gaithersburg MD 20879

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12709

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Nancy Jean Getz  |  | 2. Date of Death<br>Month Day Year<br>April 17, 1997  |  | 3. Time of Death<br>2:13PM   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Physicians Memorial Hospital   |  | 4b. City, Town, or Location of Death<br>La Plata  |  | 4c. County of Death<br>Charles   |
| Funeral<br>Director   | 5. Social Security Number<br>162-38-5321   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>50 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>April 4-16-47 | 9. Birthplace (State or Foreign Country)<br>PA   |
|   | Usual Residence of Decedent  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD   | 10b. County<br>Charles   | 10c. City, Town or Location<br>Pomfret  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br>8645 Lowell Road   |  | 10f. Zip Code<br>20675  |  | 10g. Citizen of What Country?<br>U.S.  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                 |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |  | 16b. Kind of Business/Industry<br>Home  |  |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br>Robert A. Bradley   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dorothy Mae Morris Bradley   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Richard L. Getz  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8645 Lowell Road Pomfret, MD 20675                   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Trinity Memorial  |  | 20c. Location - City or Town, State<br>4-19-97 Waldorf, MD   |
|   | 21. Signature of Funeral Service Licensee<br>David C. [Signature] M00945   |  | 22. Name and Address of Facility<br>Arehart-Echols Funeral Home<br>P.O. Box 567 La Plata, MD 20646  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Metastatic Carcinoma of Breast<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   |  |  |
| 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how Injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |
| 29b. Signature and title of certifier<br>[Signature]<br>29c. License number<br>D-20629<br>29d. Date signed (Month, Day, Year)<br>4/17/97  |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>George Wathen, MD, 11345 Penbrooke Square, Suite 103, Waldorf, Maryland 20603   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 18 1997<br>32. Registrar's Signature<br>Julia [Signature] Randall  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12710

## Certificate of Death

Reg. No.

|   |   |   |   |                                      |  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|---|---|---|---|--------------------------------------|--|--|--|---|---|----|-------------------------------|--|----|--------------------------------|-----------------|----|----------------------|------------------|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES FRANCIS GORMELEY, SR.</b>  |   |   |                                      | 2. Date of Death<br>Month <b>APR.</b> Day <b>11</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>10:00 AM</b>  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>11516 WOODWINDS COURT</b>  |   |   |                                      | 4b. City, Town, or Location of Death<br><b>CORDOVA</b>   |  | 4c. County of Death<br><b>TALBOT</b>   |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>307-22-8108</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 29, 1923</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>JERSEY CITY NJ</b> |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | Usual Residence of Decedent   |   |   |                                      |  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>TALBOT</b>  |                                      | 10c. City, Town or Location<br><b>CORDOVA</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | 10e. Street and Number<br><b>11516 WOODWINDS COURT</b>  |   |   |                                      | 10f. Zip Code<br><b>21625</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>EXECUTIVE</b>                     |                                      | 16b. Kind of Business/Industry<br><b>GENERAL SIGNAL CORP.</b>  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>FRANK GORMELEY</b>  |   |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>KATHRINE BARRY</b>   |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
| Physician<br>/Medical<br>Examiner   | 19e. Informant's Name/Relationship (Type, Print) <b>WIFE</b><br><b>MARGARET K. GORMELEY</b>   |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11516 WOODWINDS COURT, CORDOVA, MD 21625</b>   |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>ENTOMBMENT</b>   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FAIRVIEW CEMETERY 4/15 ST. JOSEPH CO., IN</b>                        |                                      | 20c. Location - City or Town, State  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | 21. Signature of Funeral Service Licensee<br><b>JOHN R. MERLERO</b>   |   |   |                                      | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD 21601</b>   |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |                                      |  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Ventricular Arrhythmia</b></td> <td>Approximate Interval Between Onset and Death<br/><b>10 min.</b></td> </tr> <tr> <td>b.</td> <td><b>Ischemic Cardiomyopathy</b></td> <td><b>10 years</b></td> </tr> <tr> <td>c.</td> <td><b>Tobacco Abuse</b></td> <td><b>40+ years</b></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |   |   |                                      |  |  |  |   | Immediate Cause (Final disease or condition resulting in death) | a. | <b>Ventricular Arrhythmia</b> | Approximate Interval Between Onset and Death<br><b>10 min.</b> | b. | <b>Ischemic Cardiomyopathy</b> | <b>10 years</b> | c. | <b>Tobacco Abuse</b> | <b>40+ years</b> | d. |  |
| Immediate Cause (Final disease or condition resulting in death)   | a.  | <b>Ventricular Arrhythmia</b>   | Approximate Interval Between Onset and Death<br><b>10 min.</b>  |                                      |  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | b.  | <b>Ischemic Cardiomyopathy</b>  | <b>10 years</b>   |                                      |  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | c.  | <b>Tobacco Abuse</b>  | <b>40+ years</b>  |                                      |  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
|   | d.  |   |   |                                      |  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b><br><b>Peripheral Vascular Disease</b><br><b>Prostate Cancer</b>   |   |   |   |                                      |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |                                      |  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                      |  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred                                 |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Richard A. Butygne</b>  |   | 29c. License number<br><b>D42816</b> |  | 29d. Date signed (Month, Day, Year)<br><b>4/11/97</b>  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Richard A. Butygne 607 Dutchmans Lane Easton MD 21601</b>  |   |   |   |                                      |  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>   |   | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |   |                                      |  |  |  |   |   |    |                               |  |    |                                |                 |    |                      |                  |    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12711

Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |  |  |   |  |
|---|---|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CONSTANCE DORIS GOEBEL</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 16, 1997</b>   |  |  |  | 3. Time of Death<br><b>10:30 A.M.</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>25 CENTENNIAL STREET</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>FROSTBURG</b>  |  |  |  | 4c. County of Death<br><b>ALLEGANY</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214 07 5581</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JAN 28, 1917</b>                           |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |
|   | 10a. State<br><b>MARYLAND</b>   |  |  |  | 10b. County<br><b>ALLEGANY</b>  |  | 10c. City, Town or Location<br><b>FROSTBURG</b>                                      |  |   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>25 CENTENNIAL STREET</b>   |  |  |  | 10f. Zip Code<br><b>21532</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.</b>  |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>COOWNER/OPERATOR</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>PLUMBING &amp; HEATING</b>   |  |  |  | 17. Father's Name (First, Middle, Last)<br><b>PATRICK McGUIRE</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>AGNES ARNOLD</b>  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>JAMES GOEBEL/SON</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1039 STONINGTON DRIVE, ARNOLD, MD 21012</b>   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FROSTBURG MEMORIAL PARK</b>  |  |  |  | 20c. Location - City or Town, State<br><b>4/19/97 FROSTBURG, MD 21532</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>SOWERS FUNERAL HOME, P.A.<br/>60 W. MAIN ST., FROSTBURG, MD 21532</b>  |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>Thromboembolism</b><br>Due to (or as a consequence of):<br><br>b. <b>Metastatic Breast Cancer</b><br>Due to (or as a consequence of):<br><br>c. <b>Adenocarcinoma of Breast</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Approximate interval Between Onset and Death<br><b>60 Minutes</b><br><b>5 Years</b><br><b>8 Years</b> |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |
|   | 28a. Date of Injury (Month, Day Year)   |  |  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |
| 29b. Signature and title of certifier<br>                                      |   |  |  | 29c. License number<br><b>D-40095</b>  |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>4/17/97</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George M. Pellegrino, M.D. 32 Corporate Dr., Grantsville, MD 21536</b> |   |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 18 1997</b>                      |   |  |  | 32. Registrar's Signature<br>   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12712

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>QUENTIN LINWOOD GRIFFEY  |  |   |  | 2. Date of Death<br>Month Day Year<br>APRIL 16, 1997   |  | 3. Time of Death<br>8:55 a.m.  |  |
| 4a. Facility Name (If not institution, give street and number)<br>14406 PINE GROVE ROAD  |  |   |  | 4b. City, Town, or Location of Death<br>ELLERSLIE  |  | 4c. County of Death<br>ALLEGANY  |  |
| 5. Social Security Number<br>217-10-4243   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>91 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>MAY 16, 1905                              |  |
| 9. Birthplace (State or Foreign Country)<br>MARYLAND   |  | 10a. State<br>MD  |  | 10b. County<br>ALLEGANY  |  | 10c. City, Town or Location<br>ELLERSLIE   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br>14406 PINE GROVE ROAD   |  | 10f. Zip Code<br>21529   |  | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>CONTRACTOR   |  | 16b. Kind of Business/Industry<br>CONSTRUCTION   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>CHARLES H. GRIFFEY  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>EMMA E. COLEMAN   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>KENNETH R. GRIFFEY/SON   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P. O. BOX 374, ELLERSLIE, MD 21529  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>PORTER CEMETERY APR 19, 1997  |  | 20c. Location - City or Town, State<br>RD, HYNDMAN, PA 15545   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Harvey H. Zeigler</i>  |  |   |  | 22. Name and Address of Facility<br>HARVEY H. ZEIGLER FUNERAL HOME<br>HYNDMAN, PA 15545-0636   |  |  |  |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Myocardial infarction<br>Due to (or as a consequence of):<br>b. Coronary artery disease<br>Due to (or as a consequence of):<br>c. Hypertension<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>10 hours<br>4 months<br>Years |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Atrial fibrillation  |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Huma Shakil</i>  |  | 29c. License number<br>52-1886172   |  | 29d. Date signed (Month, Day, Year)<br>04/17/97  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>HUMA SHAKIL, MD, 625 KENT AVENUE, CUMBERLAND, MD 21502   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 18 1997   |  | 32. Registrar's Signature<br><i>Jabin Shuckler-Randall</i>  |  |  |  |  |  |

State  
Registrar



97 12713

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOROTHY JUANITTA HILL</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 06, 1997</b>   |  | 3. TIME OF DEATH<br><b>13:15</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-22-7121</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 22, 1920</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>3429 GLEN DRIVE</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SUITLAND</b>   |  |
| 9c. COUNTY OF DEATH<br><b>PG</b>   |  |  |  | 10a. STATE<br><b>Washington, D.C.</b>   |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Washington, D.C.</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1210 18th St., N.E.</b>   |  |
| 10f. ZIP CODE<br><b>20002</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>+1</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Nurse's Aid</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Health Care</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Este Murray</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Irene Paden</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William Hill/son</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>912 7th St., N.E. Washington, D.C. 20002</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lincoln Memorial Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Suitland, Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>W. J. Jaffer</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Frazier's Funeral Home, Inc.</b><br><b>389 Rhode Island Ave., NW Wash., DC 20001</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC CANCER COLON TO LIVER</b>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. <b>LIVER METASTASIS</b>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John E. McKnight</i>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/7/97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John E. McKnight, M.D. 110 Irving Street, N.W. Suite 3A-3 Wash., DC 20010</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 09 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Buckner-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12714

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Hatcher

2. Date of Death

Month Day Year  
April 5, 1997

3. Time of Death

8:10 pm

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

218-54-9740

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 12, 1941

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Mt. Rainier

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2801 Upshur Street

10f. Zip Code

20712

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Grace

18. Mother's Name (First, Middle, Maiden Surname)

Rose Bernadette (Unavailable)

19a. Informant's Name/Relationship (Type, Print)

Elizabeth E. McPeak - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2801 Upshur Street, Mount Rainier, Maryland 20712

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

04/09/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

W.B. Geiser

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sudden

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Diabetes mellitus

Due to (or as a consequence of):

d. Chronic obst. pulm. disease

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Suresh C. Gupta

29c. License number

D14876

29d. Date signed (Month, Day, Year)

4.8.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Suresh C. Gupta, M.D. 3503 Perry Street, Mount Rainier, Maryland 20712-2141

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

John D. R. R. R.

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

8

Charles Grace

Elizabeth

Y

set, four

1934

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12715

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |  |   |  |
|--|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Johnnie Herring</b>  |   |  |   | 2. Date of Death<br>Month <b>04</b> Day <b>04</b> Year <b>97</b>   |  | 3. Time of Death<br><b>10:50 AM</b>                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Mariner Health of Southern MD</b>  |   |  |   | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |  | 4c. County of Death<br><b>Prince George's</b>                           |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-01-8726</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>05-21-18</b>                  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>   |   |  |   |  |  |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   |  |   |  |  |   |  |
|  | 10a. State<br><b>N/A</b>  |   | 10b. County<br><b>N/A</b>  |   | 10c. City, Town or Location<br><b>Washington DC</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|  | 10e. Street and Number<br><b>22 Todd Place NE # B</b>   |   |  |   | 10f. Zip Code<br><b>20002</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>5/18 1943 2/19/1946</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+)   |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>   |  | 16b. Kind of Business/Industry<br><b>Private</b>                        |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Peter Herring</b>   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucile Wilkins</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joyce Pratt/Daughter</b>   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5011 Jay Street NE #22, Washington DC 20019</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Quantico National Ceme.</b>   |   | Date <b>04/10 1997</b>   |  | 20c. Location - City or Town, State<br><b>Quantico, Virginia</b>        |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Nancy A. Perentie</b>   |   |  |   | 22. Name and Address of Facility<br><b>J.B. Jenkins Funeral Home<br/>7474 Landover Road, Landover MD 20785</b>   |  |   |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>metastatic disease</b><br>Due to (or as a consequence of):<br>b. <b>Epiglottitis Cancer</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br><br>Approximate interval Between Onset and Death<br><b>6 months</b><br><b>1 year</b> |   |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hyperlipidemia</b><br><b>B12 deficiency</b>   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28d. Describe how injury occurred                     |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |   |  |  |   |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Bernadette C.F. Soong</b>  |   |   |  | 29c. License number<br><b>D13550</b>                  |  | 29d. Date signed (Month, Day, Year)<br><b>4/7/97</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Bernadette C.F. Soong, M.D. 1106 Spring Street, Suite 2, Silver Spring, MD 20910</b>  |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 09 1997</b>  |   |   |  | 32. Registrar's Signature<br><b>J. H. [Signature]</b> |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12716

## Certificate of Death

Reg. No.

|  |  |  |  |  |  |                                |   |   |                                   |
|--|--|--|--|--|--|--------------------------------|---|---|-----------------------------------|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><u>Willie Hinesmon</u>   |  |  |  | 2. Date of Death<br>Month Day Year<br><u>April 05, 1997</u>  |                                | 3. Time of Death<br><u>8:00 p.m.</u>                            |   |                                   |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Fort Washington Hospital</u>  |  |  |  | 4b. City, Town, or Location of Death<br><u>Fort Washington</u>   |                                | 4c. County of Death<br><u>Prince's Georges</u>                  |   |                                   |
| Funeral<br>Director  | 5. Social Security Number<br><u>290-20-5752</u>  |  | 6. Sex<br><u>1</u> M <u>2</u> F  | 7. Age (in yrs. last birthday)<br><u>87</u> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><u>July 6, 1909</u>      | 9. Birthplace (State or Foreign Country)<br><u>Alabama</u>              |                                   |
|  | Usual Residence of Decedent  |  |  |  |  |                                |   |   |                                   |
| To Be Completed by Funeral Director                                  | 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>Prince George's</u>  |  | 10c. City, Town or Location<br><u>Fort Washington</u>  |                                |   | 10d. Inside City Limits<br><u>1</u> Yes <u>2</u> No                     |                                   |
|  | 10e. Street and Number<br><u>7808 Winnsboro Drive</u>  |  |  |  | 10f. Zip Code<br><u>20744</u>  |                                | 10g. Citizen of What Country?<br><u>U.S.A.</u>                  |   |                                   |
|  | 11. Marital Status<br><u>3</u> Widowed <u>4</u> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><u>1</u> Yes <u>2</u> No<br>If Yes, Give Year or Dates:                             |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> Yes <u>2</u> No Specify:                                |                                |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u> |                                   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Teacher's Aide</u> |  | 16b. Kind of Business/Industry<br><u>Escambia County Schools</u>   |                                |   |   |                                   |
|  | 17. Father's Name (First, Middle, Last)<br><u>Joshua S. Burch</u>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Harriett Murdock</u>   |  |  |                                |   |   |                                   |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br><u>Reola Lightfoot/Niece</u>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7808 Winnsboro Dr. Ft. Washington, Md. 20744</u>                             |                                |   |   |                                   |
|  | 20a. Method of Disposition<br><u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State<br><u>4</u> Donation <u>5</u> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Resurrection Cemetery</u>                             |  | Data<br><u>4/12/97</u>   |                                | 20c. Location - City or Town, State<br><u>Clinton, Maryland</u> |   |                                   |
|  | 21. Signature of Funeral Service Licensee<br><u>George P. Kalas</u>  |  |  |  | 22. Name and Address of Facility<br><u>George P. Kalas Funeral Home</u><br><u>6160 Oxon Hill Rd. Oxon Hill, Md. 20745</u>  |                                |   |   |                                   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>Lung Cancer</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><u>Dehydration</u><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death |  |  |  |  |                                |   |   |                                   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Congestive Heart Failure</u><br><u>Dehydration</u>  |  |  |  |  |                                |   |   |                                   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><u>1</u> Yes <u>2</u> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) |                                |   |   |                                   |
|  | 27. Manner of Death<br><u>1</u> Natural <u>5</u> Pending investigation<br><u>2</u> Accident <u>8</u> Could not be determined<br><u>3</u> Suicide <u>4</u> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><u>1</u> Yes <u>2</u> No                |   | 28d. Describe how injury occurred |
|  | 29a. Certifier (Check only one)<br><u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29c. License number<br><u>D 37066</u>  |                                | 29d. Date signed (Month, Day, Year)<br><u>April 6, 1997</u>     |   |                                   |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>Uchechi T. Opaigboye MD. 4467 Old Branch Ave. #105, Temple Hills, Md</u>  |  |  |  |  |                                |   |   |                                   |
|  | 31. Date filed (Month, Day, Year)<br><u>APR 08 1997</u>  |  | 32. Registrar's Signature<br><u>Jaki Anderson-Rodell</u>   |  |  |                                |   |   |                                   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the report  
describes the general situation  
of the country.

2. The second part of the report  
describes the economic situation  
of the country.

3. The third part of the report  
describes the social situation  
of the country.

4. The fourth part of the report  
describes the political situation  
of the country.

5. The fifth part of the report  
describes the cultural situation  
of the country.

6. The sixth part of the report  
describes the international situation  
of the country.

7. The seventh part of the report  
describes the future prospects  
of the country.

8. The eighth part of the report  
describes the conclusion  
of the report.

9. The ninth part of the report  
describes the appendix  
of the report.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12717

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Swann HOWARD

2. Date of Death

Month Day Year  
April 2, 1997

3. Time of Death

11:35PM

4a. Facility Name (If not institution, give street and number)

Doctors' Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577 30 8670

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 25, 1926

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2836 Belair Drive

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Carson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Long

19a. Informant's Name/Relationship (Type, Print)

James M. Howard son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14711 Bowie Rd. Laurel Maryland 20708

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

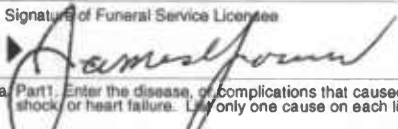
20b. Place of Disposition (Name of cemetery, crematory or other place)

April 5, 1997  
Maryland National Memorial Park

20c. Location - City or Town, State

Laurel Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.  
16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Septic Shock  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Failure  
SIP Total @ Knee Replacement  
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D45660

29d. Date signed (Month, Day, Year)

4-3-97

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

3060, Mitchellville Rd, Bowie MD 20716

State  
Registrar

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12718

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ADA

L.

HARRIS

2. Date of Death

Month Day Year

APRIL 8, 1997

3. Time of Death

5:12 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

577-30-6643

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2/16/08

9. Birthplace (State or Foreign Country)

Courtland, Va.

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4618 Lee Street, N.E.

10f. Zip Code

20019

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (14 or 5+)

College (14 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Peter F. Jones

18. Mother's Name (First, Middle, Maiden Surname)

Plusann Lepsey

19a. Informant's Name/Relationship (Type, Print)

Elizabeth L. Cantu/Daughter Same as # 10 above

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Mem. Park 4/14/97 Landover, Md.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gary D. Pratt

22. Name and Address of Facility

H.S. Washington & Sons, Inc.  
4925 Burroughs Ave., N.E.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebro-Vascular Accident weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sunder

29c. License number

D28920

29d. Date signed (Month, Day, Year)

4/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURINDER SINGH 7319A Hanover Parkway, Greenbelt MD, 20770

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

John Davidson

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12719

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys A. Hardesty

2. Date of Death

April 10, 1997

3. Time of Death

11:20 am

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

218-56-8308

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 26, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2601 Bel Pre Road

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Catterton

18. Mother's Name (First, Middle, Maiden Surname)

Mamie Armiger

19a. Informant's Name/Relationship (Type, Print)

Russell D. Hardesty - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6243 67th Court, Riverdale, Maryland 20737

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Washington National Cem. 4/14/97 Suitland, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

► *Penelope Masch-Meady*

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Bilateral Pneumonia*

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. *Sepsis with coagulase Negative*

Due to (or as a consequence of):

*Staphylococcus*

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Congestive Heart Failure**Non-insulin Dependent Diabetes**Parkinsons Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

► *Wilkinson J. Ninala*

29c. License number

D45285

29d. Date signed (Month, Day, Year)

April 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wilkinson J. Ninala, M.D. 18101 Prince Philip Drive, Olney, Maryland 20832

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

*Jalip Anderson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



## Certificate of Death

Reg. No.

97-12720

|   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM HUBBARD</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 01, 1997</b>  |   | 3. Time of Death<br><b>06:45</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>CLINTON</b>   |   | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>259-22-9073</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 2, 1925</b>                                    |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>GEORGIA</b>   |  |   |  |  |   |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |  |  |   |  |  |
|   | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>PRINCE GEORGES</b>  |  | 10c. City, Town or Location<br><b>CLINTON</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>4547 NATAHALA DRIVE</b>   |  |   |  | 10f. Zip Code<br><b>20735</b>  |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PROPERTY MANAGER</b>              |  | 16b. Kind of Business/Industry<br><b>REAL ESTATE</b>   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>BILL HUBBARD</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE LOVELACE</b>   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>PAM HUBBARD DAUGHTER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>264 MAPLE AVENUE N.W., RENTON, WASHINGTON 98055</b>                                      |   |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MAKEY &amp; WILSON FUN HOME</b>                                      |  | 20c. Date<br><b>4/10/97</b>  |   | 20d. Location - City or Town, State<br><b>LAGRANGE, GEORGIA</b>                                |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Alex S. Pope Jr., per DVR M859</b>   |  |   |  | 22. Name and Address of Facility<br><b>ALEXANDER S. POPE FUNERAL HOMES<br/>5538 MARLBORO PIKE, FORESTVILLE, MD. 20747</b>  |   |  |  |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |   |  |  |
| Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br><b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><b>b. COMPLICATED BY CARDIAC ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><b>c. PHYSICAL ALTERCATION</b><br>Due to (or as a consequence of):<br><b>d.</b>   |  |   |  |  |   |  |  |
|   | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   |  |   |  |  |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES</b>  |  |   |  |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |   |  |  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |   |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |   |  |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>4/1/97</b>  |  | 28b. Time of Injury<br><b>1800 PM</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|   | 28d. Describe how Injury occurred<br><b>PHYSICAL ALTERCATION</b>   |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>4547 NATAHALA DRIVE, CLINTON, MARYLAND</b>  |   |  |  |
|   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Alex S. Pope Jr.</b>  |  |  |   | 29c. License number<br><b>O.C.M.E.</b> |  | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 04, 1997</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>STEPHEN RADENTZ, M.D. 111 PENN STREET, BALTIMORE, MARYLAND 21201</b> |  |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 13 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson</b> |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12721

## Certificate of Death

Reg. No.

5 1/4

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Garnett Hopkins

2. Date of Death

Month

Day

Year

4

3

97

3. Time of Death

10<sup>29</sup> PM

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital Center

4b. City, Town, or Location of Death

Chesley

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

578-64-BJ339

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

NOV 16, 1948

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Suitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4711 Homer Avenue #B

10f. Zip Code

20746

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cleaner

16b. Kind of Business/Industry

Police Department

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ford

19a. Informant's Name/Relationship (Type, Print)

Lucy Hopkins wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4711 Homer Avenue #B, Suitland, Md. 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Date

4/9/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Alexander S. Pope Jr.

M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

5538 Marlboro Pike, Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Upper gastrointestinal bleeding

Due to (or as a consequence of):

b. Esophageal Varices

Due to (or as a consequence of):

c. Cirrhosis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

L. Bahadori

29c. License number

D47928

29d. Date signed (Month, Day, Year)

4/7/97

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

L. Bahadori PGHC Chesley, MD

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

Julia Davidson-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12722

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLIFTON NATHANIEL HOLMES

2. Date of Death

Month

Day

Year

MARCH

30

1997

3. Time of Death

6:40 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-14-8431

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Oct. 31, 1917

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10e. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4017 Peppertree Lane

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1943-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Tech.

16b. Kind of Business/Industry

Dept. of Defense

17. Father's Name (First, Middle, Last)

Clifton P. Holmes

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Elizabeth Holmes

19a. Informant's Name/Relationship (Type, Print)

Louise S. Holmes-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4017 Peppertree Lane, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

4-3-97

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

J. P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th Street N.W., Washington, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARHYTHMIA  
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Cerebro Vascular Accident  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

T. S. Anthony, MD

29c. License number

D 50300

29d. Date signed (Month, Day, Year)

MARCH 31, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

THOMAS J ANTHONY, MD, 11119 ROCKVILLE PIKE, #316, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

John Anthony-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12723

Item: 8, per F.H. G-747 5/30/97 reb

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |  |   |  |  |  |
|--|--|---|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERTA ARLENE HOLLAND</b>                        |   |   |   |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>2</b> Year <b>1997</b>                        |  | 3. Time of Death<br><b>11:08 AM</b>                        |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Prince Georges Hospital</b> |   |   |   |  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>                                     |  | 4c. County of Death<br><b>Prince Georges</b>               |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-70-8674</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 26, 1951</b>                                |  | 9. Birthplace (State or Foreign Country)<br><b>Wash DC</b> |  |
|  | Usual Residence of Decedent  |   |   |   |  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>PG</b>                                |   | 10c. City, Town or Location<br><b>Lanham</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>3200 Reed Street, # 2112</b>  |  |   |   | 10f. Zip Code<br><b>20706</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12th</b><br>Elementary/Secondary (0-12)      College (1-4or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Day Care Worker</b> |  |  | 16b. Kind of Business/Industry<br><b>P G County</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert Jackson</b>   |  |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gerothy Clemons</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gerothy M. Bostick Mother</b>   |  |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 2, Box 216-X, Henderson, NC 27536</b>      |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>  |   |  | Date<br><b>4-8-97</b>  |   | 20c. Location - City or Town, State<br><b>Landover, MD</b>                                     |  |  |
| 21. Signature of Funeral Service Licensee<br><b>J. P. Marshall</b>   |  |   |   |   |  | 22. Name and Address of Facility<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th Street N.W. Wash, DC 20011</b>                                   |   |  |  |  |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><b>Cardiomyopathy</b><br><b>b. Hypertension</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |   |   |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |   |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |   |   |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide   |  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                          |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>L. Nayak</b>   |  |   |   |   |  | 29c. License number<br><b>D47259</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 7, 1997</b>                                    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>L. Nayak, M.D. 6501 Landover Road, Cheverly, MD 20785</b>   |  |   |   |   |  |  |   |  |  |  |
| State Registrar  |  | 31. Date filed (Month, Day, Year)<br><b>APR 09 1997</b> |   | 32. Registrar's Signature<br><b>Julia Anderson</b>  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-698-2028.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12724

Amended #3 AG. BE, 4/12/97 &amp; 19A

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Maurice Irving Hughes

2. Date of Death

Month Day Year  
Apr. 8, 1997

3. Time of Death

10:20 AM  
8:20 p.m.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

57 9-26-4816

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
3/17/27

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4412 HAVERFORD DRIVE

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1951-52

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (1-4 or 5+)

4 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

US GOVERNMENTAL EMPLOYEE

16b. Kind of Business/Industry

US GOVERNMENT

17. Father's Name (First, Middle, Last)

BENJAMIN HUGHES, SR

18. Mother's Name (First, Middle, Maiden Surname)

MAMIE DYER

19a. Informant's Name/Relationship (Type, Print)

GAIL MARIE KING

(DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2115 W. 29TH PLACE, LOS ANGELES, CALIFORNIA

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON NATIONAL

Date

4/15/97

20c. Location - City or Town, State

ARLINGTON, VA.

21. Signature of Funeral Service Licensee

Juan Smith

22. Name and Address of Facility

JOHN T. RHINES CO., INC.  
3030 12TH ST NE, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

5 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 5 YEARS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accidental3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

HAMMETT MD

29c. License number

D39966

29d. Date signed (Month, Day, Year)

4/9/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CAROLYN A HAMMETT, MD 8218 WISCONSIN AVE. BETHESDA, MD 20814

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12725

Certificate of Death

Reg. No.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARIE S. HOFFER</b>   |   |   | 2. Date of Death<br>Month <b>4</b> Day <b>9</b> Year <b>97</b>  |  | 3. Time of Death<br><b>8:35 P.M.</b>        |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ATLANTIC GENERAL HOSPITAL</b>   |   |   | 4b. City, Town, or Location of Death<br><b>BERLIN</b>   |  | 4c. County of Death<br><b>WORCESTER</b>     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-07-0635</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>7-17-12</b>  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>   |   |   |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD.</b>   |   | 10b. County<br><b>WORCESTER</b>   |   | 10c. City, Town or Location<br><b>BERLIN</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>10842 GRAYS LANDING RD.</b>   |   |   | 10f. Zip Code<br><b>21811</b>   |  | 10g. Citizen of What Country?<br><b>USA</b> |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                     |   | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOHN H. SAUSE, JR.</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELLENORA MAGDELENA HERGERT</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>E. KAY HOFFER</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>36 TYLER ST. SELBYVILLE, DEL, 19975</b> |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARKWOOD CEMETERY</b>  |   | 20c. Location - City or Town, State<br><b>4-14 BALTIMORE, MD.</b>  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   | 22. Name and Address of Facility<br><b>ULLRICH FUNERAL HOME BERLIN, MD.</b>   |  |   |  |
|   | 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>BRAINSTEM CVA</b><br>Due to (or as a consequence of):<br>b. <b>Hypertension</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |   |  |   |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CAD</b><br><b>Poss TIA or CVA in past</b>   |   |   |   |  |   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |   |   |   |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |   |  |   |  |
| 29b. Signature and title of certifier<br><i>Roy W. Chagnway Jr. M.D.</i>  |  |   | 29c. License number<br><b>D28466</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/9/97</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROY W. CHAGNWAY JR. M.D. 9733 NEALTHWAY DR. BERLIN, MD 21811</b>   |  |   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 11 1997</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i> |   |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12726

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel Catherine HOHMAN

2. Date of Death

Month Day Year  
April 12, 1997

3. Time of Death

4:35 AM

4a. Facility Name (If not institution, give street and number)

1424 The Terrace

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

212-50-9679

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 23, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1424 The Terrace

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☒ Yes 2 ☐ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)  
homemaker

16b. Kind of Business/Industry

her own home

17. Father's Name (First, Middle, Last)

Thomas Edward McCardell

18. Mother's Name (First, Middle, Maiden Surname)

Ora Bess Middlekauff

19a. Informant's Name/Relationship (Type, Print)

Susan H. Clutz - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19609 Meadowbrook Rd., Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)  
Union Cemetery

Date

4-15-97

20c. Location - City or Town, State

McConnellsburg, Pa.

21. Signature of Funeral Service Licensee

Scott Minnich

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metabolic Lung Cancer  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael J. McCormack M.D.

29c. License number

041667

29d. Date signed (Month, Day, Year)

4.14.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael J. McCormack 11110 Medical Campus Suite 130 Hagerstown, Md. 21740

31. Date filed (Month, Day, Year)

APR 15 1997

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



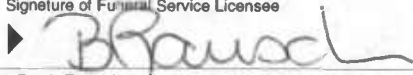

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12727

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |  |
|---|--|--|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>GRIFFORD HARRY HANCE</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 10, 1997</b>  |  | 3. Time of Death<br><b>01:36</b>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>  |  | 4c. County of Death<br><b>Calvert</b>   |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216 30 4589</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs. | 8. Date of Birth (Month, Day, Year)<br><b>March 28 1921</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                 |  |  |
|   | Usual Residence of Decedent  |  |   |  |  |  |   |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Calvert</b>   |  | 10c. City, Town or Location<br><b>Port Republic</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number<br><b>1980 Wash Hance Road</b>  |  |   |  | 10f. Zip Code<br><b>20676</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                     |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>park ranger</b>                   |  | 16b. Kind of Business/Industry<br><b>Dept. Natural Resources</b>   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Washington Hance</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marion Catterton</b>   |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth I. Hance/wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1980 Wash Hance Rd. Port Republic Md. 20676</b>  |  |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Asbury Cemetery</b>  |  | Date<br><b>4/14/97</b>   |  | 20c. Location - City or Town, State<br><b>Barstow Maryland</b>                              |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home PA</b><br><b>4405 Broomes Is. Rd. Port Republic MD 20676</b>                           |  |  |  |   |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute Myocardial Infarction 2 days</b>   |  |   |  |  |  |   | Approximate Interval Between Onset and Death   |  |
|   | Due to (or as a consequence of):<br><b>Atherosclerosis Heart 9/5</b>   |  |   |  |  |  |   |  |  |
|   | Due to (or as a consequence of):   |  |   |  |  |  |   |  |  |
|   | Due to (or as a consequence of):   |  |   |  |  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Sepsis - Lt. Lower Lobe pneumonia.</b>  |  |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |  |
|   | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D-22634</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4-10-97</b>                                       |  |  |
| State Registrar                               | 30. Name and address of certifier (Type, Print)<br><b>SHAH ASSOCIATES M.D. P.A.</b><br><b>Charlotte Hall Medical Center</b><br><b>P.O. Box 507</b><br><b>Charlotte Hall, MD 20622</b>  |  |   |  |  |  |   |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 11 1997</b><br><b>S.I. Anderson Registrar</b>  |  |   |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 12728

## Certificate of Death

Reg. No.

|   |  |   |  |   |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
|---|--|---|--|---|---|--|--|---|---|----------------------------------|--|------------------------------|----------------|----------|--|----------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>HELEN Jeanette HARTUNG</b>                  |   |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 13, 1997</b> |  | 3. Time of Death<br><b>6:13 AM</b>                             |   |   |                                  |  |                              |                |          |  |          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  | 4c. County of Death<br><b>Allegany</b>                         |   |   |                                  |  |                              |                |          |  |          |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217 10 1654</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>78</b> Yrs.  | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>October 22, 1918</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |                                  |  |                              |                |          |  |          |  |
|   | Usual Residence of Decedent  |   |  |   | 10a. State<br><b>Maryland</b>                               |  | 10b. County<br><b>ALLEGANY</b>                                 |   |   |                                  |  |                              |                |          |  |          |  |
| 10a. Street and Number<br><b>814 Trost Avenue</b>   |  | 10f. Zip Code<br><b>21502</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |                                  |  |                              |                |          |  |          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |   |                                  |  |                              |                |          |  |          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>-----Housewife-----</b>   |  | 16b. Kind of Business/Industry  |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
| 17. Father's Name (First, Middle, Last)<br><b>Howard M. Hensel</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Lashley</b>  |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Paul Hartung, Jr./Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13 Glenview Drive, LaVale, Maryland 21502</b>   |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park</b>   |  | Date<br><b>April 15, 1997</b>   |   | 20c. Location - City or Town, State<br><b>Cumberland, Maryland</b>   |  |   |   |                                  |  |                              |                |          |  |          |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Merritt-Adams Funeral Home<br/>404 Decatur Street, Cumberland, Maryland 21502</b>  |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td rowspan="4">           {         </td> <td>e. <b>Deep Venous Thrombosis</b></td> <td>Approximate Interval Between Onset and Death<br/><b>2 Years</b></td> </tr> <tr> <td>b. <b>Pulmonary Embolism</b></td> <td><b>2 Years</b></td> </tr> <tr> <td>c. _____</td> <td></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table> |  |   |  |   |   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | { | e. <b>Deep Venous Thrombosis</b> | Approximate Interval Between Onset and Death<br><b>2 Years</b> | b. <b>Pulmonary Embolism</b> | <b>2 Years</b> | c. _____ |  | d. _____ |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | {  | e. <b>Deep Venous Thrombosis</b>  | Approximate Interval Between Onset and Death<br><b>2 Years</b>                 |   |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
|   |  | b. <b>Pulmonary Embolism</b>  | <b>2 Years</b>   |   |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
|   |  | c. _____  |  |   |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
|   |  | d. _____  |  |   |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |   |                                  |  |                              |                |          |  |          |  |
|   |  |   |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |                                  |  |                              |                |          |  |          |  |
|   |  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |                                  |  |                              |                |          |  |          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |                                  |  |                              |                |          |  |          |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
|   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D 36766</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 13, 1997</b>   |  |   |   |                                  |  |                              |                |          |  |          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. VIK POONAI/955 FREDERICK STREET/CUMBERLAND, MD. 21502</b>  |  |   |  |   |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1997</b>   |  |   |  |   |   |  |  |   |   |                                  |  |                              |                |          |  |          |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



97 12729

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |                          |  |  |  |  |  |
|---|--|--------------------------|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>George Hyberg</b>  |  |                          |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 6, 1997</b>   |  | 3. TIME OF DEATH<br><b>9:55 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>324 09 0378</b>   |  | 5. SEX<br><b>1 M 2 F</b> |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>FEB. 23, 1903</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>ILLINOIS</b>   |  |                          |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>SHARON NURSING HOME</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>OLNEY</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |                          |  | 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>KENSINGTON</b>  |  |                          |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>  |  | 10e. ZIP CODE<br><b>20895</b>  |  |
| 10f. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  |                          |  | 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify:  |  |                          |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b> |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SALES MANAGER</b>  |  |                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BUSINESS MACHINES</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>(UNKNOWN)</b>   |  |                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>(UNKNOWN)</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROBERT A. HYBERG, SON</b>  |  |                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4509 WOODFIELD ROAD, KENSINGTON, MD. 20895</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  |                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>PARKLAWN CEMETERY 4/10</b>                                    |  | 20c. LOCATION — City or Town, State<br><b>ROCKVILLE, MD.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Muriel H. Barber</b>  |  |                          |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882</b>                                      |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Septic shock</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Pyelonephritis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |                          |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebral infarct</b>   |  |                          |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>   |  |                          |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b>   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>   |  |                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 8 Other (Specify)</b> |  |  |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined</b>   |  |                          |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>28b. TIME OF INJURY M 1 YES 2 NO</b>  |  |  |  |
| 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>   |  |                          |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  |                          |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Ted E. Howe - M.D.</b>   |  |  |  |
| 29c. LICENSE NUMBER<br><b>D33700</b>  |  |                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>April 6, 1997</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ted E. Howe, M.D. 7542 Overlook Dr. Boonsboro, MD 21713</b>   |  |                          |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 08 1997</b>   |  |                          |  | 32. REGISTRAR'S SIGNATURE<br><b>Gelia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12730

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Herman Heffner

2. Date of Death

Month Day Year  
April 4 1997

3. Time of Death

3:47 PM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-36-8823

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 1, 1929

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13509 Fairridge Drive

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Wire Service Operator

16b. Kind of Business/Industry

Stock Broker

17. Father's Name (First, Middle, Last)

Earle Allison Heffner

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Schindel

19a. Informant's Name/Relationship (Type, Print)

Joan Davis / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13509 Fairridge Drive, Silver Spring, Maryland 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

4/8/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

*Thomas J. Gregor*

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*ISCHEMIC BOWEL PERFORATION*

Approximate Interval Between Onset and Death

*28 Hours*

Due to (or as a consequence of):

*DIFFUSE ARTERIOSCLEROSIS*

*10 YEARS*

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Thomas J. Gregor M.D.*

29c. License number

*D16458*

29d. Date signed (Month, Day, Year)

*APR 4, 1997*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Thomas E. Dodson, MD 17904 BECKS-1A AVENUE OLNEY, MARYLAND 20932*

31. Date filed (Month, Day, Year)

*APR 09 1997*

32. Registrar's Signature

*Julia Davidson-Randall*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: # 1, 27, 28A-F PER MEO G-748 6/1-99 WR  
Items: 23 part 1, 27 per MEO G-748 6/1-99 WR

State of Maryland / Department of Health and Mental Hygiene

97 12731

Certificate of Death

Reg. No.

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ALEXANDER HOLMES</b>  |  | 2. Date of Death<br>Month Day Year<br><b>MARCH 27, 1997</b>   |   | 3. Time of Death<br><b>10:10 PM</b>                                     |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |   | 4c. County of Death<br><b>MONTGOMERY</b>                                |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-47-8983</b>  | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br>Yrs. <b>5</b> Months <b>29</b>  | 8. Date of Birth (Month, Day, Year)   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |
|  | Usual Residence of Decedent  |  |   |   |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Germantown</b>  |   | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                            |
|  | 10e. Street and Number<br><b>19359 Circle Gate Dr. # 102</b>   |  | 10f. Zip Code<br><b>20874</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |
|  | 11. Marital Status<br><b>XX</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>XX</b> No Specify:      |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> Collage (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>None</b>                                |   | 16b. Kind of Business/Industry<br><b>None</b>                           |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>Alan I. Holmes</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alba Ingrid Scarpelli</b>   |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Alan I. Holmes/ Father</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19359 Circle Gate Dr. #102 Germantown, MD 20874</b> |   |   |
|  | 20a. Method of Disposition<br><b>XX</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery April 4, 1997 Silver Spring, MD</b>   |   | 20c. Location - City or Town, State   |   |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Takoma Funeral Home, Inc.<br/>254 Carroll St. NW Washington, DC 20012</b>  |   |   |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SUDDEN INFANT DEATH, ETIOLOGY UNDETERMINED</b><br><b>SUDDEN INFANT DEATH SYNDROME [SIDS]</b> |  |   |   | Approximate Interval Between Onset and Death                            |
|  | a. Due to (or as a consequence of):  |  |   |   |   |
|  | b. Due to (or as a consequence of):  |  |   |   |   |
|  | c. Due to (or as a consequence of):  |  |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |   |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown  |  |  |   |   |   |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |  |  |   |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No  |  |  |   |   |   |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>3</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |   |   |   |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide |  | 28a. Date of Injury (Month, Day, Year)<br><b>3-27-97</b>   |   | 28b. Time of Injury<br><b>9:22</b>  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                        |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>RESIDENCE</b>   |   | 28d. Describe how injury occurred<br><b>UNKNOWN</b>   |   |
|  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>19359 CIRCLE GATE DR. GERMANTOWN, MARYLAND</b> |   |
| 29a. Certifier (Check only one)<br><b>XX</b> Medical Examiner  |  | 1 <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                            |   |   |   |
| 29b. Signature and title of certifier<br>                                       |  | 29c. License number<br><b>OCME</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MARCH 28, 1997</b>  |   |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><b>Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 09 1997</b>  |  | 32. Registrar's Signature<br>   |   |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 502.6.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12732

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marjorie E. Higgins

2. Date of Death

Month Day Year  
April 8, 1997

3. Time of Death

4:15 PM

4a. Facility Name (If not institution, give street and number)

4 Monroe Street #1004

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

033-26-6222

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 6, 1934

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4 Monroe Street, #1004

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry  
Montgomery County  
Government

17. Father's Name (First, Middle, Last)

Edward Shine

18. Mother's Name (First, Middle, Maiden Surname)

Jane Curry

19a. Informant's Name/Relationship (Type, Print)

James R. Higgins/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14207 Myer Terrace, Rockville, Maryland 20853

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☒ Donation ☐ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery Mausoleum Silver Spring, MD

Date

April 12, 1997

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 W. Montgomery Avenue,  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Minutes

b. Coronary Artery Disease

Due to (or as a consequence of):

Years

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HBP- years

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John S. Saia M.D.

29c. License number

D 10493

29d. Date signed (Month, Day, Year)

April 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John S. Saia, M.D., 809 Veirs Mill Road, #101, Rockville, Maryland 20851-1689

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12733

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Otis C. Harvey</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>7</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>4:31p.m.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Mariner Health at Circle Manor</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Kensington</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>260-22-2211</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>72</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 2, 1925</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>Georgia</b>                                     |
|  | Usual Residence of Decedent  |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Rockville</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|  | 10e. Street and Number<br><b>12630 Veirs Mill Rd.</b>  |  |   |  | 10f. Zip Code<br><b>20853</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 9th grade</b>  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Special Police Officer</b> |  |  | 16b. Kind of Business/Industry<br><b>N.C.H.P.</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Ulysses Harvey</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Ross</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary LOu Harvey (neice)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12514 Veirs Mill Rd., Rockville, MD 20853</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lebanon Cemetery</b>   |  | Date<br><b>4/14/97</b>   | 20c. Location - City or Town, State<br><b>Dawson, GA</b> |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><b>Snowden Funeral Home, P.A.<br/>246 North Washington St., Rockville, MD 20850</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cerebrovascular Accident</b><br>Died to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b.<br>Died to (or as a consequence of):<br>c.<br>Died to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>5 days</b> |  |   |  |  |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |  |   |  |
|  | 28d. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
|  | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |   |  | 29c. License number<br><b>D34032</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/9/97</b>  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JEANNE P. ASNER 3720 FARRAGUT AVE KENSINGTON MD 20895</b>   |  |   |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>APR 10 1997</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12734

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLIE HARRISON

2. Date of Death

Month

Day

Year

APRIL 5

97

3. Time of Death

4:35 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-82-0885

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

33

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 10, 1964

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7600 Maple Avenue #504

10f. Zip Code

20912

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Loan Processor

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Charlie Harrison, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Ursaline Williams

19a. Informant's Name/Relationship (Type, Print)

Barbara Farris - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

428 Emerson Street, N. W., Washington, DC 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

4/10/97

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

R. N. Horton

22. Name and Address of Facility

R. N. Horton Co., Morticians, Inc.  
600 Kennedy Street, NW, DC, 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Bilateral Pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5-6 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Respiratory failure

Due to (or as a consequence of):

5-6 days

c. Acquired Immune deficiency Syndrome 3-4 yrs

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Neutropenia

multiple opportunistic infections

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
8 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. Delap

29c. License number

D24174

29d. Date signed (Month, Day, Year)

4/5/1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PADMAJA S. UDAPL 7245 HANOVER OFFICE PARK GREENBELT 20770

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

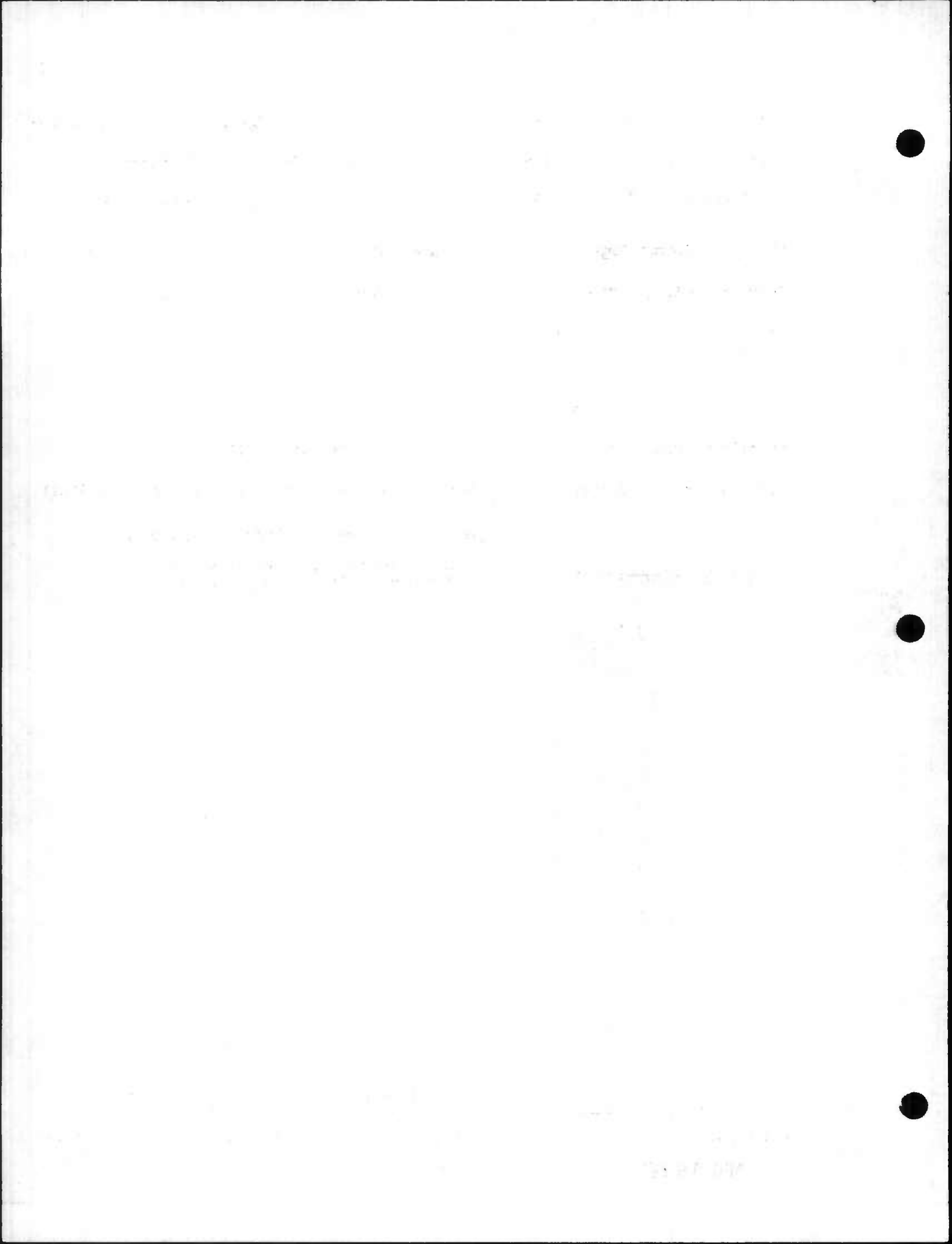
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



97 12735

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Helen R. Hohrein</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APR 14 1997</b>  |  | 3. TIME OF DEATH<br><b>1:42 PM M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-16-8920</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT. 09/11/18</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Pineview Nsg. &amp; Rehab Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Clinton, Maryland</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Prince George</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Prince George's</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Clinton</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>9106 Pine View Lane</b>   |  |
| 10f. ZIP CODE<br><b>20735</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Home Maker</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John J. Weaver Sr</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sadie (Unknown) Weaver</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John M. Bayer (Son)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9905 Cone Ct Upper Marlboro, MD 20772</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cem. 4-16-97 Baltimore, MD 21225</b>   |  |  |  |
| 20c. LOCATION — City or Town, State  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John H. Elmer</b> MO0173  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>J.H. Eberwein Mortuary<br/>4433 White Pls La White Pls, M D 20695</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>a. <b>Chronic obstructive pulmonary disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <b>Hypothyroidism</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate interval Between Onset and Death<br><b>Unknown</b><br><b>Unknown</b> |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease</b>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>28b. TIME OF INJURY M</b><br><b>28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b><br><b>28d. DESCRIBE HOW INJURY OCCURRED</b><br><b>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Arastoo Yazdani MD</b>  |  |  |  |
| 29c. LICENSE NUMBER<br><b>M41024</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APR 14, 1997</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ARASTOO YAZDANI MD Pineview Nsg. &amp; Rehab Center<br/>9106 Pineview Lane, Clinton MD 20735</b>   |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>APR 17 1997</b>   |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><b>John H. Elmer-Randall</b>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12736

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hampton

E.

Henson

2. Date of Death

April

Day

14

1997 Year

3. Time of Death

4:30AM

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

577-32-6280

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 10, 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

NANJEMOY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

#11885 HOLLY SPRING ROAD

10f. Zip Code

20662

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
0 YEARS

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

NOT APPLICABLE

17. Father's Name (First, Middle, Last)

JAMES HENSON

18. Mother's Name (First, Middle, Maiden Surname)

BUNELL CRAIG HENSON

19a. Informant's Name/Relationship (Type, Print)

MONICA HENSON-BELL/ NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11435 MARYLAND POINT ROAD, NANJEMOY, MARYLAND 20662

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TRINITY MEMORIAL GARDENS

Date

4/19/97

20c. Location - City or Town, State

WALDORF, MARYLAND

21. Signature of Funeral Service Licensee

LUDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ONE HOUR

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frank Kriger MD

29c. License number

D-50350

29d. Date signed (Month, Day, Year)

4/14/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Frank Kriger, MD., 7C Post Office Road, Waldorf, Maryland 20602

31. Date filed (Month, Day, Year)

APR 17 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12737

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LYDIA ESTELLA HARRISON

2. Date of Death

APR. 8, 1997

3. Time of Death

6:05 AM

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

Funeral  
Director

5. Social Security Number

220-01-5997

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 29, 1906

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

WITTMAN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22281 TYLER LANE

10f. Zip Code

21676

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

GEORGE TYLER

18. Mother's Name (First, Middle, Maiden Surname)

LYDIA LARRIMORE

19a. Informant's Name/Relationship (Type, Print)

VALERIA ANDERSON/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22281 TYLER LANE, WITTMAN, MD 21676

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESLEYAN CEMETERY

Date

4-11

20c. Location - City or Town, State

TILGHMAN, MD

21. Signature of Funeral Service Licensee

Joseph M. Ostrowski

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME  
200 S. HARRISON ST., EASTON, MDPhysician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RENAL FAILURE WITH DIGOXIN TOXICITY

DAYS

Due to (or as a consequence of):

b. DEHYDRATION

DAYS

Due to (or as a consequence of):

c. CELLULITIS

DAYS

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC MALNUTRITION

CONGESTIVE HEART FAILURE

CERVICAL CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Lees

29c. License number

D42005

29d. Date signed (Month, Day, Year)

4/8/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MICHAEL LEES, M.D., 606 DUTCHMAN'S LANE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

APR 14 1997

32. Registrar's Signature

Michael Lees

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12738

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Holler

2. Date of Death  
Month Day Year

April 8, 1997

3. Time of Death

2:45 P.M.

4a. Facility Name (If not institution, give street and number)

Residence - 616 Sylvan Avenue

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

218-12-5369

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Dec. 13, 1907

9. Birthplace (State or Foreign Country)

UNKNOWN

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

616 Sylvan Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Investigator

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Lucillus Free

18. Mother's Name (First, Middle, Maiden Surname)

Sarah UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

Charles Holler/step-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RT. 3 Box 47 Ridgely, W. Va. 26753

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hickory Memorial Park

Date

April 11, 1997

20c. Location - City or Town, State

Cumberland, Maryland

21. Signature of Funeral Service Licensee

Ernest A. Riley, Jr.

22. Name and Address of Facility

Leasure-Stein, Inc. 230 Baltimore Avenue

Cumberland, Md. 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Cardiomyopathy

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Signature

29c. License number

D 36766

29d. Date signed (Month, Day, Year)

4/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Vikramaditya Poonai, M.D. 955 Frederick St. Cumberland, Md. 21502

31. Date filed (Month, Day, Year)

APR 15 1997

32. Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12739

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |   |  |  |
|---|--|--|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Gerlach Hamilton</b>                       |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 10 1997</b>  |  |  |   | 3. Time of Death<br><b>1620</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  |  |   | 4c. County of Death<br><b>Allegany</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-05-9787</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 7, 1910</b>                            |   | 9. Birthplace (State or Foreign Country)<br><b>W. Va.</b>  |  |
|   | 10a. State<br><b>W. Va.</b>  |  |   |  | 10b. County<br><b>Mineral</b>   |  | 10c. City, Town or Location<br><b>Romney</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>HC 65, Box 5670</b>  |  |  |   |  | 10f. Zip Code<br><b>26757</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b> College (1-4or 5+)  |  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |  |  | 16b. Kind of Business/Industry<br><b>Kelly Springfield Tire</b>         |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Mory Lee Charlton</b>   |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cora Ellen Biser</b>  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Gerlach Flanagan</b>   |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>HC 65, Box 5670 Romney, W. Va. 26757</b>  |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arnold Cemetery</b>  |  | Date<br><b>4-13-97</b>  |  | 20c. Location - City or Town, State<br><b>Junction, W. Va.</b>                       |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |   |  | 22. Name and Address of Facility<br><b>Miller Funeral Home P. O. Drawer 1000 Romney, W. Va. 26757-1000</b>  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>10 yrs</b> |  |  |   |  |   |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PNEUMONIA CONGESTIVE HEART FAILURE</b><br><b>DEGENERATIVE JOINT DISEASE</b>  |  |  |   |  |   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how Injury occurred  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D26907</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 11, 1997</b>                         |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Harjit Sidhu, M.D., 925 Bishop Walsh Road, Cumberland, MD 21502</b>  |  |  |   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 17 1997</b>   |  |  |   |  | 32. Registrar's Signature<br>   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12740

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT JAMES JACKSON</b>   |  |   |  | 2. Date of Death<br>Month <b>MARCH</b> Day <b>29</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>8:00PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HYATTSVILLE MANOR CARE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>HYATTSVILLE</b>   |  | 4c. County of Death<br><b>PRINCE GEORGE'S</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-38-3304</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 5, 1925</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>WASH., DC</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>PRINCE GEORGE'S</b>  |  | 10c. City, Town or Location<br><b>SEAT PLEASANT</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>806 BOOKER PLACE</b>   |  | 10f. Zip Code<br><b>20743</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>NAVY 1948-46</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STATISTICAL CLERK</b>   |  | 16b. Kind of Business/Industry<br><b>FEDERAL GOVT. (VA)</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>HARRY JACKSON</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JANNIE GOODWIN</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DORSEY JACKSON/ WIFE</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>806 BOOKER PL SEAT PLEASANT, MD 20743</b> |  |
| Physician<br>/Medical<br>Examiner   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. OLIVET CEMETERY</b>  |  | Data<br><b>4-4-97</b>  |  | 20c. Location - City or Town, State<br><b>WASH., DC</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>MARSHALL'S OF MD</b><br><b>4308 SUITLAND RD SUITLAND, MD 20746</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CARCINOMA COLON WITH METASTASES</b>                        |  | Approximate Interval Between Onset and Death<br><b>YEARS</b>  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D01852</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 3, 1997</b>   |  |
| State<br>Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAUL A. DeVORE, MD 4203 QUENNSBURY RD. HYATTSVILLE, MD 20781</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 09 1997</b>   |  | 32. Registrar's Signature<br>   |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

97 12741

Item20b 4-25-97 FilmG746 W.H.Per F/H

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |   |
|---|---|---|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Marjorie B. Jeffries</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>April 7, 1997</b>   |  | 3. Time of Death<br><b>8:04 A.M.</b>   |   |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>10450 Lottsford Road, #4208</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Mitchellville</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-38-1802</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 9, 1918</b>  | 9. Birthplace (State or Foreign Country)<br><b>Minor, VA</b>  |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |   |
| To Be Completed by Funeral Director   | 10e. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Mitchellville</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>10450 Lottsford Road, #4208</b>  |   |   |  | 10f. Zip Code<br><b>20721</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                            |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retired Librarian</b>                 |  | 16b. Kind of Business/Industry<br><b>Government</b>  |  |  |   |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>Thomas Ball</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laverta Norman</b>   |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Junius L. Jeffries - Husband</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20721 10450 Lottsford Road, #4208, Mitchellville, MD</b>  |  |  |   |
|   | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery</b>  |  | Date<br><b>4/11/97</b>   | 20c. Location - City or Town, State<br><b>Arlington, VA</b>  |  |   |
|   | 21. Signature of Funeral Service Licensee<br><i>John T. Stewart III</i>   |   | 22. Name and Address of Facility<br><b>STEWART FUNERAL HOME, Inc.<br/>4001 Benning Road, N.E., Washington, D. C.</b>                                  |  |  |  |  |   |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic ovarian cancer</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>1 year</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |
|   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28e. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                             |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |   |  |  |  |  |   |
| 29b. Signature and title of certifier<br><i>Dennis Priebat</i>  |   |   |   | 29c. License number<br><b>DC10200</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>4/9/97</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dennis Priebat, M.D., 110 Irving Street, N. W., Washington, D. C. 20010</b>  |   |   |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 11 1997</b>   |   | 32. Registrar's Signature<br><i>John Andrew Randall</i>   |   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12742

|  |   |  |   |   |   |  |   |   |
|--|---|--|---|---|---|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Virginia Frances Johnson  |  |   |   | 2. Date of Death<br>Month Day Year<br>04 07 97  |  | 3. Time of Death<br>7:45 pm   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>Wilson Health Care Center   |  |   |   | 4b. City, Town, or Location of Death<br>Gaithersburg  |  | 4c. County of Death<br>Montgomery   |   |
| Funeral<br>Director  | 5. Social Security Number<br>578-44-9117  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>94 Yrs.     | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Birth (Month, Day, Year)<br>Dec. 18, 1902  | 9. Birthplace (State or Foreign Country)<br>Maine |
|  | Usual Residence of Decedent   |  |   |   |   |  |   |   |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Chevy Chase  |  | 10d. Inade City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
|  | 10e. Street and Number<br>8702 Preston Place  |  |   |   | 10f. Zip Code<br>20815  |  | 10g. Citizen of What Country?<br>United States  |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                  |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) 3  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher / Director                       |   | 16b. Kind of Business/Industry<br>Pre-school  |  |   |   |
|  | 17. Father's Name (First, Middle, Last)<br>Clair V. Heald   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Clarice Estes  |  |   |   |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Rebecca J. Serpan   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as 10   |  |   |   |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |   | Data<br>4-9-97  |  | 20c. Location - City or Town, State<br>Beltsville, Maryland                                       |   |
|  | 21. Signature of Funeral Service Licensee<br>Eileen L. Rapp   |  |   |   | 22. Name and Address of Facility<br>Rapp Funeral Services, P.A.<br>933 Gist Avenue, Silver Spring, Maryland 20910   |  |   |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediata Cause (Final disease or condition resulting in death)<br>a. <u>Pneumonia</u><br>Due to (or as a consequence of):<br>b. <u>Dementia</u><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |  |   |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   |   |  |   |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |   |  |   |   |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |   |  |   |   |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |   |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No              |   |
|  | 28d. Describe how injury occurred   |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |   |   |  |   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |   |  |   |   |
| 29b. Signature and title of certifier<br>Elliott R. Goldstein  |   |  |   | 29c. License number<br>D03581                 |   | 29d. Date signed (Month, Day, Year)<br>April 7, 1997 |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Elliott R. Goldstein 9410 Old Georgetown Rd. Bethesda, Md. 20814   |   |  |   |   |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br>APR 10 1997   |   |  |   | 32. Registrar's Signature<br>Davidson-Randall |   |  |   |   |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12743

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wilfred Edward Janakka

2. Date of Death

April 5, 1997

3. Time of Death

2:00 a.m.

4a. Facility Name (If not institution, give street and number)

Montgomery County General

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

521.20.6926

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 24, 1913

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

15200 Clondesley Court

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mining Engineer

16b. Kind of Business/Industry

Mining

17. Father's Name (First, Middle, Last)

Toivo Edward Janakka

18. Mother's Name (First, Middle, Maiden Surname)

Ida Erica Jarvi

19a. Informant's Name/Relationship (Type, Print)

Jean Janakka/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15200 Clondesley Ct. Silver Spring, Md. 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Comfort Crematory

Date

4/7/97

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.  
5130 Wisconsin Ave. N.W. Washington DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Hemorrhagic CVA

Approximate Interval Between Onset and Death

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN, NIDDM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

XX ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43202

29d. Date signed (Month, Day, Year)

April 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. Ozanne-Blankford, M.D. 3305 North Leisure World Blvd. Silver Spring, Md. 20906

State  
Registrar

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12744

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Imogene Frances Johnson

2. Date of Death

Month Day Year  
April 8, 1997

3. Time of Death

1:25 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

233-44-1806

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sep. 29, 1916

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1918 Alberti Drive

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Henson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Williams

19a. Informant's Name/Relationship (Type, Print)

Barbara J. Zavatchan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1918 Alberti Drive Silver Spring, Maryland 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 4/11/97 Silver Spring, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. Kevin Gutowski

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic Shock  
Due to (or as a consequence of):b. Ischemic Cardiomyopathy  
Due to (or as a consequence of):c. Coronary Disease  
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Davidson-Randall

29c. License number

D24819

29d. Date signed (Month, Day, Year)

4/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce Zinsmeister MD 8830 CAMERON ST Suite 601 Silver Spring MD 20910

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

J. Davidson-Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760,

JW

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



Amended # 19a, N.D.S.  
4/14/97, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12745

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RALPH

CARLTON

KRAUS, SR.

2. Date of Death  
Month Day Year  
April 12 1997

3. Time of Death  
10:39 AM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital & Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

705-12-4922

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 16, 1920

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

119 SOUTH ALLEGANY STREET

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

ASSISTANT MANAGER

16b. Kind of Business/Industry

UNDERGARMENT FACTORY

17. Father's Name (First, Middle, Last)

GEORGE W. KRAUS

18. Mother's Name (First, Middle, Maiden Surname)

LEOTA V. SPANGLER

19a. Informant's Name/Relationship (Type, Print)

LEOTA L. KRAUS / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

119 S. ALLEGANY ST., CUMBERLAND, MD 21502

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

SUNSET MEMORIAL PARK

Date

4/15/97

20c. Location - City or Town, State

CUMBERLAND, MD

21. Signature of Funeral Service Licensee

*George W. Kraus*

22. Name and Address of Facility

GEORGE W. KRAUS FUNERAL HOME, P.A.  
202 GREENE ST., CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatic Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Week

b. Proteus Mirabilis Septicemia

Due to (or as a consequence of):

2 Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*William Lamm*

29c. License number

D 25406

29d. Date signed (Month, Day, Year)

April 13, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. William Lamm

47 Virginia Avenue

Cumberland, Md

21502

31. Date filed (Month, Day, Year)

APR 14 1997

Registrar's Signature

*John A. Randall*

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12746

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Mildred Lulu Keller  
2. Date of Death Month Day Year April 10, 1997  
3. Time of Death 3:56 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Reeders Memorial Home  
4b. City, Town, or Location of Death Boonsboro  
4c. County of Death Washington

5. Social Security Number 212-80-4161  
6. Sex 1 ☐ M 2 ☒ F  
7. Age (In yrs. last birthday) 87 Yrs.  
8. Date of Birth (Month, Day, Year) Aug 13 1909  
9. Birthplace (State or Foreign Country) Maryland

10a. State Maryland  
10b. County Washington  
10c. City, Town or Location Hagerstown  
10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 613 Washington Avenue  
10f. Zip Code 21740  
10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No  
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker  
16b. Kind of Business/Industry Her own home

17. Father's Name (First, Middle, Last) Charles Kline  
18. Mother's Name (First, Middle, Maiden Surname) Lizzie Mae Barkdoll

19a. Informant's Name/Relationship (Type, Print) Larry E. Keller/Son  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10917 Oak Forest Drive Hagerstown, Maryland 21740

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park  
20c. Location - City or Town, State Hagerstown, Maryland  
Date 4/14/97

21. Signature of Funeral Service Licensee Fred L. Keller  
22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) a. Pneumonia  
Due to (or as a consequence of):  
b. Chronic obstructive lung disease  
Due to (or as a consequence of):  
c.  
Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

2 weeks

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure  
Coronary artery Disease

23b. Did tobacco use contribute to the cause of death?  
1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury M  
28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Dr. Zafar Malik  
29c. License number D44996  
29d. Date signed (Month, Day, Year) April 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Zafar Malik 20311 Lappans Road, Boonsboro, Maryland 21713/301-432-8470

31. Date filed (Month, Day, Year) APR 11 1997  
32. Registrar's Signature John D. Barker

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12747

|   |   |   |   |   |  |   |  |   |  |
|---|---|---|---|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EMMA KENNEDY</b>   |   |   |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>9</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>2:00 PM</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1704 BRIGHTSEAT ROAD #103</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>LANDOVER</b>  |   | 4c. County of Death<br><b>PRINCE GEORGE</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>424-70-6893</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>JAN 25, 1917</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>ALA.</b> |  |
|   | Usual Residence of Decedent   |   |   |   |  |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>PRINCE GEORGE</b>   |   | 10c. City, Town or Location<br><b>LANDOVER</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>1704 BRIGHTSEAT ROAD #103</b>  |   |   |   | 10f. Zip Code<br><b>20785</b>  |   | 10g. Citizen of What Country?<br><b>U. S. A.</b>   |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                     |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>DAVID AMERSON</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>ANNIE MATHIS</b>   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>BERTHA L. KENNEDY</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1704 BRIGHTSEAT RD. #103 LANDOVER, MD 20785</b>  |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SHILOH CEMETERY</b>  |   | Data<br><b>4/16/97</b>   |   | 20c. Location - City or Town, State<br><b>LIVINGSTON, ALA.</b>                                 |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Theodore C. Pinckney</i>  |   |   |   | 22. Name and Address of Facility<br><b>PINCKNEY-SPANGLER FUNERAL HOME</b><br><b>524 - 8TH ST., N. E. WASH., D. C. 20002</b>  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>congestive heart failure</b><br>Due to (or as a consequence of):<br><br>b. <b>Atherosclerotic heart disease</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   | Approximate Interval Between Onset and Death<br><br>years<br>years   |   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>senile dementia with recurrent aspiration</b>  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)                       |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                       |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i> |   | 29c. License number<br><b>022780</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/9/97</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Peter M Schuster MD 7500 Greenway Ctr. Dr Ste 430 Greenbelt, Md 20770</b>  |   |   |   |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 10 1997</b>   |   |   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12748

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Kelly

2. Date of Death

March 29 1997

3. Time of Death

6:08PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

579-28-6518

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 11, 1914

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

DISTRICT HEIGHTS

10d. Inside City Limits

☐ Yes 2 ☐ No

10e. Street and Number

1300 EDENVILLE DRIVE

10f. Zip Code

20747

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

LICENSED PRACTICAL NURSE

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

DOUGLAS SMITH

18. Mother's Name (First, Middle, Maiden Surname)

LULA BREVARD

19a. Informant's Name/Relationship (Type, Print)

JAMES KELLY SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1300 EDENVILLE DR. DISTRICT HEIGHTS, MD 20747

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HARMONY CEMETERY

Date

4/5

20c. Location - City or Town, State

LANDOVER, MARYLAND

21. Signature of Funeral Service Licensee

Kimberly C. Briscoe-Tomic

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME  
4308 SUITLAND ROAD SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Cardiopulmonary Arrest

Due to (or as a consequence of):

30 mins

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. Cerebrovascular Accident

Due to (or as a consequence of):

4 yrs

c. Alzheimer's Dementia

Due to (or as a consequence of):

6 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recent Pneumonia Treated

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gary W. Jones MD

29c. License number

D30111

29d. Date signed (Month, Day, Year)

April 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary W. Jones MD 11305 Pitsea Dr Beltsville MD 20705-1757

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

John A. ...

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12749

|  |   |  |   |   |   |  |  |
|--|---|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas Knestout</b>                                |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>5</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>2:15 PM</b>   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital</b> |  |   | 4b. City, Town, or Location of Death<br><b>Cheverly</b>   |   | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>140 20 9445</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>April 16, 1929</b>   |  |
|  | 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |   | 10c. City, Town or Location<br><b>Bowie</b> |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Usual Residence of Decedent  |   |  |   |   |   |  |  |
| 10e. Street and Number<br><b>2601 Fair Lane</b>  |   |  |   | 10f. Zip Code<br><b>20715</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>46-49</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cryptologist</b>  |   |   | 16b. Kind of Business/Industry<br><b>National Security Agency</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>August Knestaut</b>  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Aschenbrenner</b>   |   |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>Caroline M. Knestout Wife</b>   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2601 Fair Lane Bowie Maryland 20715</b>   |   |  |  |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery</b>  |   | Date<br><b>April 9, 1997</b>                |  | 20c. Location - City or Town, State<br><b>Clinton Maryland</b>                                 |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |  |   | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.<br/>16000 Annapolis Road Bowie Maryland 20715</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Renal failure</b><br>Due to (or as a consequence of):<br>b. <b>as a result of myocardial Infarction</b><br>Due to (or as a consequence of):<br>c. <b>Cardiac Arrest</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |   |  |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |   |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   |  | 27e. Date of injury (Month, Day Year)   |   | 27b. Time of injury<br>M                    |  | 27c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |
|  |   |  | 27d. Describe how injury occurred   |   |   | 27f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 27e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  | 27f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |   |   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |   |  |   | 29c. License number<br><b>D09776</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/6/97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Barry Rosenberg M.D. 6501 Landover Rd Cheverly Md 20780</b>   |   |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 11 1997</b>  |   |  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12750  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BRIDGET A. KEVILLY

2. Date of Death

Month

Day

Year

04

08

1997

3. Time of Death

12:45 PM

4a. Facility Name (If not institution, give street and number)

LARKIN CHASE NURSING

4b. City, Town, or Location of Death

BOWIE

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

068 05 2207

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 7, 1909

9. Birthplace (State or Foreign Country)

Ireland

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

Maryland Prince George's

Bowie

10d. Inside City Limits

10d. Inside City Limits

10e. Street and Number

12111 Reardon Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Maurice Kelliher

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Connor

19a. Informant's Name/Relationship (Type, Print)

Kathleen Harris Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12111 Reardon Lane Bowie Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Sacred Heart Cemetery April 11, 1997 Bowie Maryland

21. Signature of Funeral Service Licensee

Robert E. Evans, Inc.

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Due to (or as a consequence of):

Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 DAY

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease  
Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Siph MD

29c. License number

D45660

29d. Date signed (Month, Day, Year)

4-8-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

3060, Mitchellville Rd, Bowie MD 20716

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

Julia D. Parker-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12751

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOUIS S. KERDOCK

2. Date of Death

Month Year  
MARCH 30, 1997

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

MORNINGSIDE HOUSE OF LAUREL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

124-12-6372

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 29, 1913

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

MD

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

8805 Kensington Parkway

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
9College (1-4 or 5+)  
-----

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Negative Engraver

16b. Kind of Business/Industry

Fed. Gov't.

17. Father's Name (First, Middle, Last)

Louis Kerdock

18. Mother's Name (First, Middle, Maiden Surname)

Veronica Govalis

19a. Informant's Name/Relationship (Type, Print)

Louis J. Kerdock (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4111 Gallatin St. Hyattsville, MD. 20781

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate Of Heaven Cemetery

Date

4/2

20c. Location - City or Town, State

Silver Spring, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Chambers Funeral Homes, P.A.

5801 Cleveland Ave. Riverdale, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC Carcinoma Prostate 10 years  
Due to (or as a consequence of):  
b. Transitional Cell Carcinoma Bladder 10 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D10242

29d. Date signed (Month, Day, Year)

3/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Morten W. SAPIRO MD 5225 Pook Hill Road Bethesda

31. Date filed (Month, Day, Year)

APR 01 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12752

|  |  |   |  |  |  |  |   |  |
|--|--|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH KASPER</b>   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 6, 1997</b>   |  | 3. Time of Death<br><b>10:20 PM</b>                         |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>FOX CHASE REHAB. &amp; NURSING CTR.</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b> |  | 4c. County of Death<br><b>MONTGOMERY</b>                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>226-14-8159</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.             |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 15, 1918</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>  |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>MONTGOMERY</b>                             |  | 10c. City, Town or Location<br><b>SILVER SPRING</b>         |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>2607 JENNINGS ROAD</b>   |  | 10f. Zip Code<br><b>20902</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ELECTRICIAN</b>   |  | 16b. Kind of Business/Industry<br><b>ELECTRICAL</b>  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>PETER KASPER</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELIZABETH BENDICK</b>  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS. MARY PEARLENE KASPER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2607 JENNINGS ROAD, SILVER SPRING, MD 20902</b>  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARKLAWN MEMORIAL</b>  |  | 20c. Location - City or Town, State<br><b>4/9/97 ROCKVILLE, MD</b>   |  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>FRANCIS J. COLLINS FUNERAL HOME<br/>500 UNIVERSITY BLVD. W. SILVER SPRING, MD 20901</b>   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>VENTRICULAR ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><br>b. <b>ISCHEMIC CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br><br>c. <b>ACUTE ASPIRATION SYNDROME</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><br><b>1 MINUTE</b><br><br><b>SEVERAL YRS.</b><br><br><b>5 MINUTES</b>  |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CEREBROVASCULAR ACCIDENT</b><br><br><b>DYSYPHEGIA</b><br><br><b>CASTROPARESIS</b>   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D41881</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/7/97</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ALLAN S. ROGERS, MD 8630 FENTON ST., SUITE 900 SILVER SPRING, MD 20910</b>  |  |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 09 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12753

Amended #17, 4/22/97, JW, Mont. Cty.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret J. Kenney

2. Date of Death

Month  
AprilDay  
8Year  
1997

3. Time of Death

4 30 AM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Friends Nursing Home

4b. City, Town, or Location of Death

Sandy Spring

4c. County of Death

Montgomery

5. Social Security Number

578-32-0461

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 21, 1922

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10e. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12412 Lima Drive

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph W. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Marie Lowe

19a. Informant's Name/Relationship (Type, Print)

Mr. William D. Kenney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12412 Lima Drive, Silver Spring, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

4/11/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Michael P. H.

22. Name and Address of Facility

Francis J. Collins Funeral Home

500 University Blvd., W. Silver Spring, MD 20901

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 Days

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Parkinson's Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Peptic Ulcers

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael P. H.

29c. License number

D25947

29d. Date signed (Month, Day, Year)

April 8, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANK SARAY, MD 5540 TEN DAYS RD, CHARLISSE, MD 21029

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12754

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEAN MARIE LYNCH KASZYNSKI

2. Date of Death

Month Day Year  
April 4, 1997

3. Time of Death

1:00 P.M.

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

361-14-4224

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 24, 1925

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12928 Dean Road

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Montgomery County  
Public Schools

17. Father's Name (First, Middle, Last)

William J. Lynch

18. Mother's Name (First, Middle, Maiden Surname)

Martha Gleason

19a. Informant's Name/Relationship (Type, Print)

Edwin Kaszynski / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12928 Dean Road, Wheaton, Maryland 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)April 7, 1997  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta M00348

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.  
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Prostatic Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 year

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jeanne P. Asher MD

29c. License number

D34032

29d. Date signed (Month, Day, Year)

4/4/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JEANNE P. ASHER 3720 FARRAGUT AVE KENSINGTON MD 20895

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

John Davidson-Rodale

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12755

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sybil M. Ketchum

2. Date of Death

Month Day Year  
April 3, 1997

3. Time of Death

07:51 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

219-36-8839

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 29, 1911

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

906 LaGrande Road

10f. Zip Code

20903

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Elementary Education

17. Father's Name (First, Middle, Last)

Harry Leuty

18. Mother's Name (First, Middle, Maiden Surname)

Lena Marie Winegar

19a. Informant's Name/Relationship (Type, Print)

Harry W. Ketchum, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4877 Battery Lane Bethesda, Maryland 20814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donellon 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Matropolitan Crematory

Date

4/4/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD. 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Approximate Interval Between Onset and Death

5 mins

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Right acetabulum Fracture

48 hrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

April 1 1997

28b. Time of Injury

7:00 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fall

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

906 LaGrande Rd SS md

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Tauber

29c. License number

D08546

29d. Date signed (Month, Day, Year)

April 9 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tauber 8218 Wisconsin Ave Bethesda md.

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

Lia Davidson-Randall

State Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12756

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |                                 |  |  |  |   |  |   |  |   |  |
|---|---|--|---|--|---|---------------------------------|--|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARJORIE HERTZBERG KAUFMAN</b>   |  |   |  |   |                                 | 2. Date of Death<br>Month Day Year<br><b>APRIL 6, 1997</b>                     |  | 3. Time of Death<br><b>11:50 AM</b>  |   |  |   |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MAPLEWOOD PARK PLACE</b>   |  |   |  |   |                                 | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>                        |  | 4c. County of Death<br><b>MONTGOMERY</b>   |   |  |   |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578.62.3607</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F<br><b>XX</b>   |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  |                                 | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 24, 1912</b>                   |  | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON DC</b>                                   |   |  |   |  |   |  |
|   | Usual Residence of Decedent   |  |   |  |   |                                 |  |  |  |   |  |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>BETHESDA</b>  |                                 |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |   |  |   |  |
|   | 10e. Street and Number<br><b>9707 OLD GEORGETOWN ROAD</b>   |  |   |  | 10f. Zip Code<br><b>20814</b>   |                                 | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                 |  |  |   |  |   |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |   |  |   |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>4</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |                                 |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                                    |  |   |  |   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JULIUS HERTZBERG</b>  |  |   |  |   |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CAROLINE HOLLANDER</b> |  |  |   |  |   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>ELINOR S. BLACKSTONE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6112 TUCKERMAN LANE ROCKVILLE, MD. 20852</b>  |                                 |  |  |  |   |  |   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. COMFORT CREMATORY</b>  |                                 | Data<br><b>4/8/97</b>  |  | 20c. Location - City or Town, State<br><b>ALEXANDRIA, VA.</b>                                      |   |  |   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility <b>JOSEPH GAWLER'S SONS INC</b><br><b>5130 WI AVE NW WASHINGTON DC 20016</b>   |                                 |  |  |  |   |  |   |  |   |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CARDIOPULMONARY ARREST</b><br>Due to (or as a consequence of):<br>b. <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>Due to (or as a consequence of):<br>c. <b>ARTERIOSCLEROSIS</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |                                 |  |  |  |   | Approximate Interval Between Onset and Death   |   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |                                 |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |   |  |
|   |   |  |   |  |   |                                 |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |                                 |  |  |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |  |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |   |  |   |  |
|   |   |  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |                                 |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |   |                                 |  |  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>5313</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 6, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BERNANDO KOTELANSKI, M.D. 4301 MASSACHUSETTS NE #1002 WDC</b>  |   |  |   |  |   |                                 |  |  |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 09 1997</b>   |   |  |   |  |   |                                 |  |  |  | 32. Registrar's Signature<br>  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12757

## Certificate of Death

Reg. No.

|   |  |   |  |   |   |  |  |   |
|---|--|---|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Edward, John Kelly</i>  |   |  |   | 2. Date of Death<br>Month <i>4</i> Day <i>17</i> Year <i>97</i> |  | 3. Time of Death<br><i>12:59 AM</i>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Charles County Vsg and Rehab Center</i> |   |  |   | 4b. City, Town, or Location of Death<br><i>La Plata</i>         |  | 4c. County of Death<br><i>Charles</i>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><i>050-07-1627</i>  |   | 6. Sex<br><i>15 M</i> <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>89</i> Yrs.  | If Under 1 Year<br>Months Days                                  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><i>SEPT. 24, 1907</i>                                   | 9. Birthplace (State or Foreign Country)<br><i>NEW YORK</i> |
|   | Usual Residence of Decedent  |   |  |   |   |  |  |   |
| 10a. State<br><i>MARYLAND</i>   |  | 10b. County<br><i>CHARLES</i>   |  | 10c. City, Town or Location<br><i>LA PLATA</i>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><i>7454 WOODHAVEN DRIVE</i>   |  |   |  | 10f. Zip Code<br><i>20646</i>   |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>FINANCIAL OFFICER</i>   |   | 16b. Kind of Business/Industry<br><i>CON-EDISON ELEC.CO.</i>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><i>WILLIAM KELLY</i>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>THEODSIA McGETTIGAN</i>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>GAIL SEITH (DAUGHTER)</i>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>SAME AS #10</i>   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>SACRED HEART CEMETERY</i>  |   | Date<br><i>4-21-97</i>   |  | 20c. Location - City or Town, State<br><i>LA PLATA, MD.</i> |
| 21. Signature of Funeral Service Licensee<br><i>Michael L...</i>  |  |   |  | 22. Name and Address of Facility<br><i>RAYMOND FUNERAL SERVICE<br/>LA PLATA, MARYLAND 20646</i>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Cerebral Infarction</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>Due to (or as a consequence of):</i><br><br><i>Due to (or as a consequence of):</i><br><br><i>Due to (or as a consequence of):</i> |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypertension</i><br><i>Pneumonia</i><br><i>Gangrene left Foot</i>  |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of injury<br>M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                           |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>Henry L. Burke M.D.</i>   |  | 29c. License number<br><i>001009</i>  |   | 29d. Date signed (Month, Day, Year)<br><i>4-17-97</i>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>HENRY L. BURKE, M.D. LA PLATA, MARYLAND 20646</i>  |  |   |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><i>APR 17 1997</i>   |  | 32. Registrar's Signature<br><i>John Andrew Randall</i>   |  |   |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





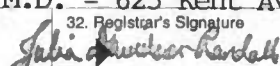
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12758

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |                                 |  |  |  |  |  |  |  |
|---|---|--|---|--|---|--|---------------------------------|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MARY LOUISE KRAPP</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>17</b> Year <b>1997</b>   |  |                                 |  | 3. Time of Death<br><b>8:20A.M.</b>  |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CUMBERLAND NURSING HOME</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>   |  |                                 |  | 4c. County of Death<br><b>ALLEGANY</b>   |  |  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-07-1910</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 7, 1910</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |
|   | Usual Residence of Decedent   |  |   |  |   |  |                                 |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>ALLEGANY</b>  |  | 10c. City, Town or Location<br><b>BOWLING GREEN</b>   |  |                                 |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
|   | 10e. Street and Number<br><b>LONG AVENUE</b>  |  |   |  | 10f. Zip Code<br><b>21502</b>   |  |                                 |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FACTORY WORKER</b>  |  |                                 |  | 16b. Kind of Business/Industry<br><b>BOBBIN STORES<br/>CELANESE CORPORATION</b>      |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>ALBERT E. ELLIS</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LYDIA MAY BURALL</b>  |  |                                 |  |  |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>RONALD E. ELLIS</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8783 HICKORY HILL - WALKERSVILLE, MD 21793</b>  |  |                                 |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SUNSET MEMORIAL PARK</b>   |  |                                 |  | Date<br><b>4/19/97</b>   |  | 20c. Location - City or Town, State<br><b>CUMBERLAND, MD</b>                                       |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>GEORGE-UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE ST., CUMBERLAND, MD 21502</b>  |  |                                 |  |  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) a. <b>Coronary artery disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { |  |   |  |   |  |                                 |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>10 years</b>  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery Disease</b><br><b>cerebrovascular Accident</b>   |  |   |  |   |  |                                 |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |                                 |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                                 |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                 |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |                                 |  |  |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D33280</b>  |  |                                 |  | 29d. Date signed (Month, Day, Year)<br><b>April 17, 1997</b>                         |  |  |  |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sunil K. Gupta, M.D. - 625 Kent Avenue, Cumberland, MD 21502</b>   |  |   |  |   |  |                                 |  |  |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 21 1997</b>   |  |   |  | 32. Registrar's Signature<br>  |  |                                 |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12759

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT L. KLINE

2. Date of Death

April 16, 1997

3. Time of Death

3:03 am

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

216-22-5025

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 29, 1929

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12526 Blue Valley RD SE

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired Boilermaker

16b. Kind of Business/Industry

CSX Corp.

17. Father's Name (First, Middle, Last)

Hugh L. Kline

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn O. (Andrews)

19a. Informant's Name/Relationship (Type, Print)

Susan G. Kline--wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12526 Blue Valley Road SE; Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Davis Memorial Cemetery

Date

04/19

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced large cell lymphoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

May 1987

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

10 yrs MD

29c. License number

D 23371

29d. Date signed (Month, Day, Year)

April 17 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Q. Zaman, Johnson Heights Medical Bldg., Cumberland, MD 21502

31. Date filed (Month, Day, Year)

APR 18 1997

32. Registrar's Signature

John H. Hurd

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12760

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Harry A. KUYKENDALL</b>  |   |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>3</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>3:30 A.M.</b>   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>232-26-3737</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 19, 1908</b>                                    |  |
|   | 10e. State<br><b>Md.</b>  |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>900 Renfren St.</b>  |   |   |  | 10f. Zip Code<br><b>21221</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>                      |  | 16b. Kind of Business/Industry<br><b>Gas Station</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Mike J. Kuykendall</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hattie Wratchford</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gertie Kuykendall</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>900 Renfren St. Baltimore, Md. 21221</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bethel Cemetery</b>  |  | Date<br><b>4-6-97</b>  |  | 20c. Location - City or Town, State<br><b>Oldfields, W. Va.</b>                                |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Miller Funeral Home P. O. Drawer 1000 Romney, W. Va. 26757-1000</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Ruptured abdominal aortic aneurysm</b><br>Due to (or as a consequence of):<br><b>b. Arteriosclerosis cardiovascular disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |  |  |  |
|   | Approximate Interval Between Onset and Death<br><b>1 year</b><br><b>10 years</b>  |   |   |  |  |  |  |  |
|   | Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>History of myocardial infarction</b><br><b>Congestive heart failure</b><br><b>Pulmonary fibrosis</b> |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   | 28d. Describe how injury occurred  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |   |   |   | 29c. License number<br><b>D 17728</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 3, 1997</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Ba Yin Oung 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 17 1997</b>   |   |   |   | 32. Registrar's Signature<br> |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

IN SENATE,  
January 11, 1911.

REPORT  
OF THE  
ATTORNEY GENERAL,  
JAMES C. CLARK,  
FOR THE YEAR 1910.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.  
1911.



Amended # 196, 4/15/97,  
MHA, Allegany County

97 12761

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |                                 |  |  |
|--|--|---|--|--|--|---|---------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARY HELENA LANAM  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 12, 1997   |  | 3. TIME OF DEATH<br>7:15 P. M.  |                                 |  |  |
| 4. SOCIAL SECURITY NUMBER<br>219-14-6347   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>87 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>March 1, 1910  |                                 | 8. BIRTHPLACE (State or Foreign Country)<br>WEST VIRGINIA  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>DEVLIN MANOR NURSING HOME  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CUMBERLAND  |  |   | 9c. COUNTY OF DEATH<br>ALLEGANY |  |  |
| RESIDENCE OF DECEDENT  |  |   |  | 10c. CITY, TOWN OR LOCATION<br>CUMBERLAND  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |                                 |  |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>ALLEGANY   |  | 10f. ZIP CODE<br>21502   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                 |  |  |
| 10e. STREET AND NUMBER<br>220 SOMMERVILLE AVENUE   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                 | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5 College (1-4 or 5+) 5  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>DISHWASHER & WAITRESS           |  | 16b. KIND OF BUSINESS/INDUSTRY<br>RESTAURANT  |                                 |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN RUMMER   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>BERTHA CRABTREE   |  |   |                                 |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ROBERT F. LANAM  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7324 EAST SPRINGBROOK CT., MIDDLETOWN, MD 21769 |  |   |                                 |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>FT. ASHBY CEMETERY 4/16/97   |  | 20c. LOCATION — City or Town, State<br>ft. Ashby, WV   |  |   |                                 |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>George Upchurch   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>GEORGE-UPCHURCH FUNERAL HOME, P.A.<br>202 GREENE ST., CUMBERLAND, MD 21502                                   |  |   |                                 |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): 7 yrs<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Dilated Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): 10 yrs<br>c. Atherosclerotic Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): 20 yrs<br>d. |  |   |  |  |  |   |                                 | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>IHD, COPD, Congestive heart failure, hypertension, liver failure<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |                                 |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |                                 | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |                                 |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |                                 |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>A. J. Bollino M.D.  |  |   |  | 29c. LICENSE NUMBER<br>D17565  |  | 29d. DATE SIGNED (Month, Day, Year)<br>April 13, 1997   |                                 |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>A. J. Bollino M.D., 955 Frederick St Cumberland MD 21502  |  |   |  |  |  |   |                                 |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 15 1997   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Andrew Rodes   |  |   |                                 |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.








Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12762

## Certificate of Death

Reg. No.

|   |   |   |  |   |   |   |  |  |
|---|---|---|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Elizabeth Helena LEPPERT</b>                         |   |  |   | 2. Date of Death<br>Month/Day/Year<br><b>Apr/12/1997</b>    |   | 3. Time of Death<br><b>0305</b>                            |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Homewood Retirement Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Williamsport</b> |   | 4c. County of Death<br><b>Washington</b>                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>158-14-2385</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 9, 1905</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                     |   | 10a. State<br><b>N. J.</b>   |   | 10b. County<br><b>Middlesex</b>                             |   | 10c. City, Town or Location<br><b>New Brunswick</b>        |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>formerly of Ellen Street</b>   |   | 10f. Zip Code<br><b>19802</b>   |  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>dental floss worker</b>   |   | 16b. Kind of Business/Industry<br><b>pharmaceutical</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Yeager</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Weber</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Doris deLumeau - daughter</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13629 Donneybrook Dr., Hagerstown, Md. 21742</b>  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Peter's Cemetery</b>   |  | 20c. Date<br><b>4-15-97</b>   |   | 20d. Location - City or Town, State<br><b>New Brunswick, N.J.</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>MINNICH FUNERAL HOME</b><br><b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Aspiration pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |   | Approximate Interval Between Onset and Death<br><b>days.</b>  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b><br><b>Hypothyroidism</b>  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |  |  |
| 28b. Time of Injury<br><b>1</b> Yes <input type="checkbox"/> No <input type="checkbox"/>  |   | 28c. Describe how injury occurred   |  | 28d. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D26806</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/14/97</b>   |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>AND: 747 Norton Ave Hagerstown MD 21742</b>  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>   |   | 32. Registrar's Signature<br>  |  | State Registrar   |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner




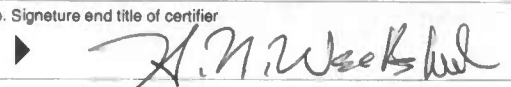

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12763

## Certificate of Death

Reg. No.

|                                     |   |  |   |                                |  |
|-------------------------------------|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Paul Franklin LITTEN</b>   |  | 2. Date of Death<br>Month <b>April</b> Day <b>9</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>12:37 PM</b>  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |                                | 4c. County of Death<br><b>Washington</b>   |
| Funeral<br>Director                 | 5. Social Security Number<br><b>214-09-4494</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|                                     | 8. Date of Birth (Month, Day, Year)<br><b>March 16, 1914</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent   |  |   |                                |  |
|                                     | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Washington</b>   | 10c. City, Town or Location<br><b>Fairplay</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|                                     | 10e. Street and Number<br><b>17319 Spielman Road</b>  |  | 10f. Zip Code<br><b>21733</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |                                |  |
|                                     | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TV Technician</b>  |  | 16b. Kind of Business/Industry<br><b>Retail Sales</b>   |                                |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Thomas Edgar Litten</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie W. Liskey</b>  |                                |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Georgia F. Litten - Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17319 Spielman Rd. Fairplay, MD 21733</b>   |                                |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Manor Cemetery</b>   |                                | 20c. Location - City or Town, State<br><b>4-12-97 Tilghmanton, Maryland</b>  |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Osborne Funeral Home 425 South Conococheague St. Williamsport, MD 21795</b>  |                                |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Atherosclerotic cardiac vascular disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                | Approximate Interval Between Onset and Death<br><b>40</b>  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|                                     | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |
|                                     | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|                                     | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                |  |
|                                     | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D11266</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>April 9 97</b>   |
|                                     | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>H.N. Weeks 580 Northern Av Hagerstown, Md</b>  |  |   |                                |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>APR 11 1997</b>   |  | 32. Registrar's Signature<br>  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12764

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy V. Larkin

2. Date of Death

Month 4 Day 7 Year 97

3. Time of Death

0602

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

579-12-7827

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 28, 1919

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1117 Glacier Avenue

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cosmetologist

16b. Kind of Business/Industry

Drug Fair

17. Father's Name (First, Middle, Last)

William Emory Dove

18. Mother's Name (First, Middle, Maiden Surname)

Sallie Walker

19a. Informant's Name/Relationship (Type, Print)

Richard E. Larkin/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1117 Glacier Ave., Capitol Heights, Md. 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cem. 4/14/97

Date

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home  
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease  
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Clark Holmes, M.E.O.

29c. License number

AACHY DME  
D05735

29d. Date signed (Month, Day, Year)

4/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clark Holmes, M.E.O. 3001 Hospital Dr. Cheverly, Md. 20785

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

John Andrew Ricketts

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12765

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mae L. Luppino

2. Date of Death

April 6, 1997

3. Time of Death

6:30 A. M.

4a. Facility Name (If not institution, give street and number)

6602 Trowbridge Place

4b. City, Town, or Location of Death

Temple Hills

4c. County of Death

Prince George's

5. Social Security Number

129-22-7586

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 13, 1930

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Prince George's10c. City, Town or Location  
Temple Hills

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6602 Trowbridge Place

10f. Zip Code

20748

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Self-Employed - Owner

16b. Kind of Business/Industry

Antique Store

17. Father's Name (First, Middle, Last)

William Jacob Hildebrand

18. Mother's Name (First, Middle, Maiden Surname)

Amelia Helen Mayo

19a. Informant's Name/Relationship (Type, Print)

Dominic R. Luppino/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6602 Trowbridge Pl. Temple Hills, Md. 20748

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resurrection Cemetery

Date

4/10/97

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home  
6160 Oxon Hill Rd. Oxon Hill, Md. 2074523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. METASTATIC NON SMALL CELL LUNG CANCER

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

DC10200

29d. Date signed (Month, Day, Year)

4/7/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis A. Priebat, M.D. 110 Irving St., N. W. Washington, D. C. 20010

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12766

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

TALMADGE W. LITTLE

2. Date of Death

Month

Day

Year

3. Time of Death

0920 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

5. Social Security Number

217 44 0111

6. Sex

M

20 F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 19, 1915

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

8502 Nicholson Street

10f. Zip Code

20784

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No

Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Personel Officer

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

John Little

18. Mother's Name (First, Middle, Maiden Surname)

Antnett Reed

19a. Informant's Name/Relationship (Type, Print)

Lorene G. Little Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8502 Nicholson Street New Carrollton Md. 20784

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 4/8/97 Cheltenham Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert E. Evans Pro

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 10 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation

2 Accident

3 Suicide

4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Rosson MD

29c. License number

D 16897

29d. Date signed (Month, Day, Year)

4/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Rosson MD 5701 85th Ave. New Carrollton Md.

31. Date filed (Month, Day, Year)

APR 08 1997

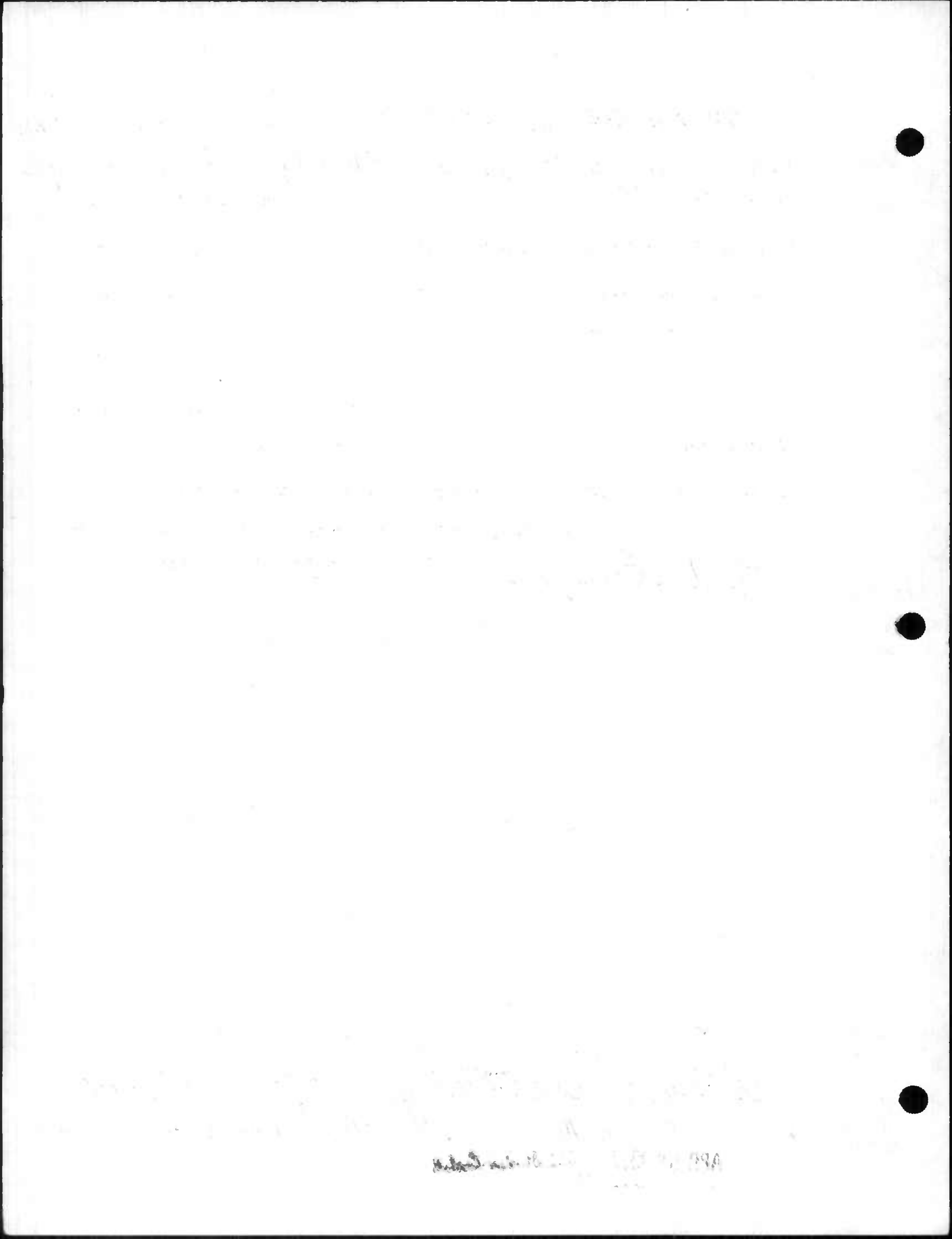
32. Registrar's Signature

John D. ...

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

97 12767

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |   |  |  |
|--|--|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><i>Hester Sansbury Ladson</i>  |  |   |  | 2. Date of Death<br>Month <i>April</i> Day <i>3</i> Year <i>1997</i>   |   | 3. Time of Death<br><i>2:20 PM</i>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><i>Prince George's Hospital</i>  |  |   |  | 4b. City, Town, or Location of Death<br><i>Chesley</i>   |   | 4c. County of Death<br><i>Prince George's</i>  |  |
| 5. Social Security Number<br><i>578 05 9654</i>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>84</i> Yrs. | 8. Date of Birth<br>(Month, Day, Year)<br><i>Feb. 3, 1913</i>  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i> |  |  |
| Usual Residence of Decedent  |  |   |  |  |   |  |  |
| 10a. State<br><i>Maryland</i>  |  | 10b. County<br><i>Prince George's</i>   |  | 10c. City, Town or Location<br><i>Bowie</i>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><i>12700 N. Cliff Rd.</i>  |  |   |  | 10f. Zip Code<br><i>20720</i>  |   | 10g. Citizen of What Country?<br><i>United States</i>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Benefit's Supervisor</i>   |   | 16b. Kind of Business/Industry<br><i>Insurance</i>   |  |
| 17. Father's Name (First, Middle, Last)<br><i>Charles Sansbury</i>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Gussie Padgett</i>   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>William E. Ladson Husband</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>12700 N. Cliff Rd. Bowie Maryland 20715</i>  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Epiphany Episcopal Church Cemetery Forestville Md.</i>   |  | 20c. Location - City or Town, State<br><i>Forestville Md.</i>  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><i>Robert E. Evans Funeral Home, Inc.<br/>16000 Annapolis Rd. Bowie Md. 20715</i>  |   |  |  |
| 23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><i>Cold as Arrest</i><br>Due to (or as a consequence of):<br><br><i>Coronary Artery Disease</i><br>Due to (or as a consequence of):<br><br><i>Chronic Renal Failure</i><br>Due to (or as a consequence of): |  |   |  |  |   |  | Approximate Interval Between Onset and Death   |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Were an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |   |  | 29c. License number<br><i>D2619D</i>   |   | 29d. Date signed (Month, Day, Year)<br><i>4/4/97</i>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>David L Sigal MD 3231 Superior Lane AI Bowie</i>  |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 08 1997</i>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

9

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12768

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>CARL LITTLEJOHN</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 1, 1997</b>   |  | 3. Time of Death<br><b>3:10pm</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>11801 CAPLINGER ROAD</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>251-48-7908</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 7, 1935</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>MONTGOMERY</b>   |  | 10c. City, Town or Location<br><b>SILVER SPRING</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>11801 CAPLINGER ROAD</b>   |  | 10f. Zip Code<br><b>20904</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES OF AMERICA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2 years</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CARPENTER</b>   |  | 16b. Kind of Business/Industry<br><b>FEDERAL GOVERNMENT</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ROBERT LITTLEJOHN</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MILDRED TONEY</b>   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>JEANETTE LITTLEJOHN</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11801 CAPLINGER RD. SILVER SPRING, MD. 20904</b>  |  |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>NORBECK CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>OLNEY MARYLAND</b>   |  | 20d. Date<br><b>4/8/97</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>JOHNSON &amp; JENKINS FUNERAL HOME<br/>716 KENNEDY ST NW WDC 20011</b>   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Cancer</b><br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  | Approximate interval Between Onset and Death<br><b>2 years</b>  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>021463</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-3-97</b>   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BRUCE A. SILVER, MD 2101 MEDICAL PARKWAY SILVER SPRING, MD 20902</b>  |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 08 1997</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12769

## Certificate of Death

Reg. No.

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ARMAS LiljEBERG</b>  |  | 2. Date of Death<br>Month <b>April</b> Day <b>3</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>6:15am</b>  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Prince George's Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>  |   | 4c. County of Death<br><b>Prince George's</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>003-12-6567</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>05-24-22</b> | 9. Birthplace (State or Foreign Country)<br><b>New Hampshire</b>   |
|   | Usual Residence of Decedent   |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Prince George's</b>                                      | 10c. City, Town or Location<br><b>Cheverly</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>5709 Landover Road</b>   |  | 10f. Zip Code<br><b>20784</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:        |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4+</b> College (1-4 or 5+) <b>4+</b>                   |   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>  |  | 16b. Kind of Business/Industry<br><b>Private</b>   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Liljeberg</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Syrjanen</b>  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>John Liljeberg/Brother</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>119 Amherst Street, Amherst, New Hampshire 03031</b> |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>  |   | 20c. Location - City or Town, State<br><b>Beltsville, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br><b>Nancy A. Percantie</b>  |  | 22. Name and Address of Facility<br><b>J.B. Jenkins Funeral Home<br/>7474 Landover Road, Landover, Maryland 20785</b>                                    |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute cerebral hemorrhage</b><br>Due to (or as a consequence of):<br><b>b. Tripple vessel coronary Artery Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Due to (or as a consequence of): |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular Accident</b>   |   |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |  |   |  |
| 28a. Date of Injury (Month, Day Year)<br><b>4/3/97</b>  |   |  |  |   |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |   |  |
| 28d. Describe how Injury occurred   |   |  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Arvind M. Mehta MD</b>  |   |  |  |   |  |
| 29c. License number<br><b>D 27366</b>   |   |  |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>4/3/97</b>  |   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARVIND M. MEHTA 7100 Baltimore Ave. #509, College Park MD 20740</b>  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 07 1997</b>   |   |  |  |   |  |
| 32. Registrar's Signature<br><b>John D. [Signature]</b>   |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

97 12770

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Joseph Lynch

2. Date of Death  
Month Day Year

April 2, 1997

3. Time of Death

11:02 AM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

121-28-9734

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Oct. 30, 1938

9. Birthplace (State or Foreign  
Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

901 Laredo Road

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 196113. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Territory Manager - Sales

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

John Lynch

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Vianne

19a. Informant's Name/Relationship (Type, Print)

Juanita F. Lynch

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

901 Laredo Road Silver Spring, Maryland 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn

Date

4/7/97 Rockville, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. Kevin Gutowski

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

Minutes

Due to (or as a consequence of):

Sequitally list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesteremia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hugo G. Graziani, M.D.

29c. License number

Do8188

29d. Date signed (Month, Day, Year)

April 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hugo G. Graziani, M.D. 717 Pershing Drive Silver Spring, Maryland 20910

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12771

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>John D Large</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>02</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>7:15 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>283-16-4170</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>75</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 8, 1921</b>                                  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Rockville</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>407 Farragut Avenue</b>  |  | 10f. Zip Code<br><b>20851</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Civil Engineer</b>  |  | 16b. Kind of Business/Industry<br><b>Montgomery County Government</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John L. Large</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Dinsmore</b>  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret B. Large/Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>407 Farragut Ave., Rockville, Maryland 20851</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>   |  | Date<br><b>April 5, 1997</b>   |  | 20c. Location - City or Town, State<br><b>Rockville, Maryland</b>                           |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Randy Jank</b> M00198  |  |   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Rockville, Inc.<br/>300 West Montgomery Avenue<br/>Rockville, Maryland 20850-2805</b>                                     |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pneumonia</b><br>Due to (or as a consequence of):<br><b>b. Chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of):<br><b>c. Acute myocardial infarction</b><br>Due to (or as a consequence of):<br><b>d. Respiratory Failure</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>2 wks</b><br><b>10 yrs.</b><br><b>2 wks</b><br><b>2 wks.</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28b. Describe how injury occurred   |  | 28c. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><b>David A. Holden MD</b>  |  | 29c. License number<br><b>D47791</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 03, 1997</b>                                |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David A. Holden MD 809 Veirs Mill Rd, Rockville, MD 20851</b>   |  |   |  | 31. Data filed (Month, Day, Year)<br><b>APR 07 1997</b>  |  |   |  |
|   | 32. Registrar's Signature<br><b>Julia Davidson-Rendell</b>   |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



97 12772

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LAURA H. LARSON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 3 1997</b>   |  | 3. TIME OF DEATH<br><b>1140A</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>578-62-0093</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sep. 7, 1911</b>                           |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Care Matrix Nursing Home</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |   |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Howard</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Savage</b>   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>8472 Savage Guilford Road</b>  |  |  |   |
| 10f. ZIP CODE<br><b>20763</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Harnek</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Gryzbosz</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William Larson, Jr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17617 Stafford Court, Olney, Maryland 20832</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery 4/7</b>  |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, Maryland</b>   |  | 20d. DATE<br><b>4/7</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hines-Rinaldi Funeral Home<br/>11800 New Hampshire Avenue<br/>Silver Spring, Maryland 20904</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Carcinoma of Lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>1 yr</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive pulmonary disease</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |  |   |
| 28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>DO 6674</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>4/4/97</b>                                 |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MYRON L. LENKOW MD<br/>2309 SHOREFIELD RD<br/>WHEATON MD</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 07 1997</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 687, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12773

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>EMIL W. LENTCHNER  |  |   |  | 2. Date of Death<br>April 5 1997   |  | 3. Time of Death<br>6:00 am  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>GENESIS NURSING HOME-LAYHILL   |  |   |  | 4b. City, Town, or Location of Death<br>SILVER SPRING  |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>071-32-8085   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>89 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>DECEMBER 13/07                                |  |
|   | 9. Birthplace (State or Foreign Country)<br>NEW YORK   |  | 10a. State<br>MARYLAND  |  | 10b. County<br>MONTGOMERY  |  | 10c. City, Town or Location<br>OLNEY   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>15115 INTERLACHEN DRIVE #923  |  | 10f. Zip Code<br>20906   |  | 10g. Citizen of What Country?<br>UNITED STATES                                       |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>DENTIST  |  | 16b. Kind of Business/Industry<br>DENTAL   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>ISADORE LENTCHNER   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>SARAH BRUCHNER  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>LAURI JOSEPH DAUGHTER  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7908 COACH STREET POTOMAC, MARYLAND 20854   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>JUDEAN MEMORIAL GARDENS   |  | 20c. Location - City or Town, State<br>OLNEY, MARYLAND   |  | 20d. Date<br>4/7/97  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br>1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ASCVD<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br>Years  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D43202  |  | 29d. Date signed (Month, Day, Year)<br>April 5, 1997                                 |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>C. Ozanne-Blankford MD   |  |   |  | 31. Date filed (Month, Day, Year)<br>APR 08 1997   |  |  |  |
|   | 32. Registrar's Signature<br>  |  |   |  | 33. Date of Death<br>APR 05 1997   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12774

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph P. Loftus, Sr.</b>  |   | 2. Date of Death<br>Month <b>April</b> Day <b>4</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>8:30A.</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7JCrescent Road</b>  |   | 4b. City, Town, or Location of Death<br><b>Greenbelt</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-38-0856</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>June 27, 1902</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>  |
|   | 10c. City, Town or Location<br><b>Greenbelt</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
|   | 10e. Street and Number<br><b>7JCrescent Road</b>  |   | 10f. Zip Code<br><b>20770</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:      |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>                  |  |  |
|   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Executive</b>  |   | 16b. Kind of Business/Industry<br><b>United States Govn't</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Martin James Loftus</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Carey</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Katharine L. Boucher (Daughter)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>34 Windward Drive Severna Park, Maryland 21146</b> |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>4/7/1997 Silver Spring, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br><i>Donald V. Borgwardt</i>   |   | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Road Beltsville, Maryland 20705</b>                 |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |   |  |  | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>Cardiac Arrhythmia</b>  |   |  |  | <b>Months</b>  |
|   | Due to (or as a consequence of):  |   |  |  |  |
|   | <b>Coronary Heart Disease</b>   |   |  |  | <b>Years</b>   |
|   | Due to (or as a consequence of):  |   |  |  |  |
|   | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |  |  |  |
|   | Due to (or as a consequence of):  |   |  |  |  |
|   | Due to (or as a consequence of):  |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive Pulmonary Disease</b>  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28d. Describe how injury occurred   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |
| 29b. Signature and title of certifier<br><i>David M. Goldman</i>  |   | 29c. License number<br><b>DO 4374</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 4, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David M. Goldman, M.D. 7500 Hanover Pkwy., #105 Greenbelt, Maryland 20770</b>  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1997</b>   |   | 32. Registrar's Signature<br><i>Juha Davidson-Rendell</i>   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

10-18-14

Wm. B. Smith

10-18-14

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12775

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Georganna Leyhe

2. Date of Death

Month  
AprilDay  
11,Year  
1997

3. Time of Death

2:10 P.M.

4a. Facility Name (If not institution, give street and number)

Cuppett- Weeks Nursing Home

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

214-16-2041

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 3, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RT. #3, Bedford Road

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

School System

17. Father's Name (First, Middle, Last)

Walter Guy Krause

18. Mother's Name (First, Middle, Maiden Surname)

Lulu May (Fazenbaker)

19a. Informant's Name/Relationship (Type, Print)

Katherine M. Davis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

314 Maryland Ave., Westernport, MD 21562

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sunset Memorial Park

Date

4/18/97

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

William S. Kight

22. Name and Address of Facility

Kight Funeral Home  
309-311 Decatur St., Cumberland, MD. 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause of death.Immediate Cause (Final  
disease or condition  
resulting in death)

pneumonia

Approximate  
Interval Between  
Onset and Death

10 days

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Walter K. Naumann M.D.

29c. License number

D25759

29d. Date signed (Month, Day, Year)

April 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Walter K. Naumann, M.D., PO Box 247, 106 Cemetery Road, Accident, MD 21520

31. Date filed (Month, Day, Year)

APR 17 1997

32. Registrar's Signature

John Anderson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12776

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH ANDERSON LEACH SR.

2. Date of Death

Month Day Year  
APRIL 15 1997

3. Time of Death

1605 P.M.

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

488-12-1900

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)  
AUG 16 1919

9. Birthplace (State or Foreign Country)

MISSOURI

Usual Residence of Decedent

10a. State  
MARYLAND10b. County  
ALLEGANY10c. City, Town or Location  
FROSTBURG

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

225 ARMSTRONG AVE.

10f. Zip Code

21532

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW1

13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR IN MANUFACTURING

16b. Kind of Business/Industry

MANUFACTURING

17. Father's Name (First, Middle, Last)

JOSEPH ANDERSON LEACH

18. Mother's Name (First, Middle, Maiden Surname)

PHOEBE DUNN

19a. Informant's Name/Relationship (Type, Print)

BRIDGET LEACH WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

225 ARMSTRONG AVE. FROSTBURG, MARYLAND 21532

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CUMBERLAND CREMATORY APRIL 18 1997 CUMBERLAND MARYLAND

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME  
404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ruptured abd. aortic aneurysm

2 weeks

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Acute Myocardial infarction

12 days

Due to (or as a consequence of):

c. Stroke

10 days

Due to (or as a consequence of):

d. Renal failure

9 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic colitis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Sivan Pillai M.D.

29c. License number

D 13233

29d. Date signed (Month, Day, Year)

APRIL 16 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. SIVAN PILLAI M.D., 915 SETON DRIVE CUMBERLAND, MD. 21502

31. Date filed (Month, Day, Year)

APR 16 1997

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



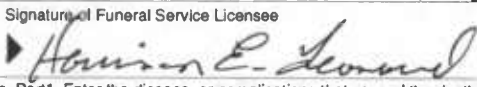
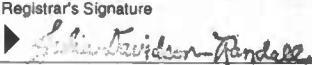
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12777

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |                                      |  |
|--|--|--|---|--|---|--------------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JACK LEWIS LARRIMORE</b>  |  |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>16</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>11:27 AM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>   |  |   | 4b. City, Town, or Location of Death<br><b>EASTON</b>  |   | 4c. County of Death<br><b>TALBOT</b> |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-22-2622</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  |                                      | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 7, 1923</b>                                     |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Talbot</b>  |                                      | 10c. City, Town or Location<br><b>St. Michaels</b>   |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>208 Lincoln Ave.</b>  |  | 10f. Zip Code<br><b>21663</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |                                      | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates: <b>Navy</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>7</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Federal Law Enforcement</b>   |  | 16b. Kind of Business/Industry<br><b>Treasury Dept.</b>   |                                      |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Oliver Larrimore</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marjorie Slater</b>  |   |                                      |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Judson Kepner Larrimore Son</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>697 Gist Rd. Westminster, Maryland 21157</b> |   |                                      |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Capitol Crematory April 17, 1997</b>   |  | 20c. Location - City or Town, State<br><b>Dover, Delaware</b>   |                                      |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Maryland 21663</b>  |  |   |                                      |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. SEPSIS</b><br>Due to (or as a consequence of):<br><b>b. METASTATIC PANCREATIC CARCINOMA</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Approximate Interval Between Onset and Death<br><b>HOURS</b><br><b>MONTHS</b> |  |   |  |   |                                      |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |                                      |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |                                      |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |   |                                      |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |   |                                      |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                      |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  |   |                                      |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |                                      |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |                                      |  |
| 29b. Signature and title of certifier<br>                       |  |  | 29c. License number<br><b>D 48064</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-16-97</b>   |                                      |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Kevin Stitely 505 Dutchman's Lane Easton, MD 21601</b>  |  |  |   |  |   |                                      |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>APR 18 1997</b>  |  | 32. Registrar's Signature<br>  |  |   |                                      |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12778

|                                     |   |  |   |                                |  |
|-------------------------------------|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BEULAH LOUISE MANGOLD</b>  |  | 2. Date of Death<br>Month <b>April</b> Day <b>13</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>2:52 AM</b>   |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital &amp; Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |                                | 4c. County of Death<br><b>Allegany</b>   |
| Funeral<br>Director                 | 5. Social Security Number<br><b>215-20-5080</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|                                     | 8. Date of Birth<br>Month Day Year<br><b>Aug 1, 1925</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>WV</b>   |                                |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent   |  |   |                                |  |
|                                     | 10a. State<br><b>MD</b>   | 10b. County<br><b>Allegany</b>   | 10c. City, Town or Location<br><b>Cumberland</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|                                     | 10e. Street and Number<br><b>410 Louisiana Avenue</b>   |  | 10f. Zip Code<br><b>21502</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |                                |  |
|                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |                                |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Oscar Wesley Simmons</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elsie Ann (Eckhart)</b>   |                                |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shirley Wisenburg-daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>410 Louisiana Avenue Cumberland MD 21502</b>  |                                |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hillcrest Memorial Park</b>  |                                | 20c. Location - City or Town, State<br><b>04/15 Cumberland, MD</b>   |
|                                     | 21. Signature of Funeral Service Licensee<br><b>James F. Scarpelli</b>  |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>  |                                |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Anoxic Encephalopathy</b><br>Due to (or as a consequence of):<br><br>b. <b>Hypercapnea (Elevated Carbon Dioxide)</b><br>Due to (or as a consequence of):<br><br>c. <b>Hypoxia</b><br>Due to (or as a consequence of):<br><br>d. |  |   |                                | Approximate Interval Between Onset and Death<br><br><b>4 Days</b><br><br><b>4 Days</b><br><br><b>4 Days</b>  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |
|                                     | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |                                |  |
|                                     | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |  |
|                                     | 29b. Signature and title of certifier<br><b>J. V. Poonai</b>  |  | 29c. License number<br><b>D36766</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>Apr 13, 1997</b>   |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. V. Poonai 955 Frederick Street Cumberland, Md. 21502</b>   |  |   |                                |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>APR 14 1997</b>   |  | 32. Registrar's Signature<br><b>J. V. Poonai</b>  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12779

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie Marie MAHONE

2. Date of Death

Month Day Year  
April 15, 1997

3. Time of Death

10:50 PM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

218-30-8638

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 27, 1938

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

623 George Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

0

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

her own home

17. Father's Name (First, Middle, Last)

David H. Morningstar

18. Mother's Name (First, Middle, Maiden Surname)

Daisy B. Johnson

19a. Informant's Name/Relationship (Type, Print)

William R. Mahone - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

623 George St., Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Memorial Park

Date

4-18-97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott Minnich

22. Name and Address of Facility MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Approximate Interval Between Onset and Death

month

Due to (or as a consequence of):

b. Mediastinal Lymphoma

2 years

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward W. Ditto, III

29c. License number

D01062

29d. Date signed (Month, Day, Year)

April 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward W. Ditto, III, 217 W. Washington St. Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

APR 18 1997

32. Registrar's Signature

John A. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Amel # 1 wash co 216 April 18, 1997

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12780

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BRUCE

Emmons

E.

MATTESON

2. Date of Death

Month

Day

Year

APRIL

14

1997

3. Time of Death

7:00PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1002 JEFFERSON BLVD.

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

177-54-0546

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year

May 31 1959

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

Maryland Washington

Hagerstown

10a. Street and Number

1002 Jefferson Blvd.

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

0

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Mechanic

16b. Kind of Business/Industry

Power Company

17. Father's Name (First, Middle, Last)

Harold E. Matteson

18. Mother's Name (First, Middle, Maiden Summa)

Mary Jane Eakle

19a. Informant's Name/Relationship (Type, Print)

Mary J. Matteson/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

4-17-97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott Minnich

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hanging

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☒ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

Found 4/14/97

28b. Time of Injury

19:45 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject hanged self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

basement of residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1002 Jefferson Boulevard Hagerstown, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

APRIL 15, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 18 1997

32. Registrar's Signature

John A. ...

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12781

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

REGINA GRAHAM MCCANN

2. Date of Death

April 13, 1997

3. Time of Death

6:20PM

4a. Facility Name (If not institution, give street and number)

Colton Villa Nursing Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

230-30-9664

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 18, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

102 Manor Drive, Bld. 60, Apt. 102

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Medical Secretary

16b. Kind of Business/Industry

Medical Doctor's Office

17. Father's Name (First, Middle, Last)

William Graham

18. Mother's Name (First, Middle, Maiden Surname)

Helen Haggett

19a. Informant's Name/Relationship (Type, Print)

Kathleen M. Bachtell, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 Maple Avenue, Smithsburg, MD 21783

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Smithsburg Crematory

Date

April 14

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

Kathy A. Younger

22. Name and Address of Facility

Douglas A. Fiery Funeral Home  
1331 Eastern Blvd. N., Hagerstown, Maryland 2174223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. BREAST CARCINOMA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

20 years.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. METASTATIC DISEASE TO BRAIN

Due to (or as a consequence of):

c. X

Due to (or as a consequence of):

d. X

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

none

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

N/A

28b. Time of  
Injury

N/A

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

N/A

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

N/A

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Henry J. G. Hap

29c. License number

D28365

29d. Date signed (Month, Day, Year)

4.14.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MANZARJ. SHAFI 368 MILL STREET HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

APR 14 1997

32. Registrar's Signature

John D. H. Hap

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or item 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12782

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |  |  |  |
|--|--|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Mary Agnes MOATS                                 |   |  |  | 2. Date of Death<br>Month Day Year<br>April 13 1997 |  | 3. Time of Death<br>2220                             |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital |   |  |  | 4b. City, Town, or Location of Death<br>Hagerstown  |  | 4c. County of Death<br>Washington                    |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-14-2391   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>Yrs. 79           |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 16, 1917 |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |   | 10a. State<br>Maryland   |  | 10b. County<br>Washington                           |  | 10c. City, Town or Location<br>Hagerstown            |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>13017 Resh Road   |  | 10f. Zip Code<br>21740   |   | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: white                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (14 or 5+) 0  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>homemaker  |  | 16b. Kind of Business/Industry<br>her own home   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Darlington Davis  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Rachel Chaney  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>John C. Moats - son  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13017 Resh Road, Hagerstown, Md. 21740  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery   |  | 20c. Location - City or Town, State<br>Hagerstown, Maryland  |   | 20d. Date<br>4-17-97   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740  |  |  |   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>ASYSTOLE</u><br>Due to (or as a consequence of):<br>b. <u>ACUTE MYOCARDIAL INFARCTION</u><br>Due to (or as a consequence of):<br>c. <u>ATHEROSCLEROSIS</u><br>Due to (or as a consequence of):<br>d. <u>DIABETES AND HYPERTENSION</u><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Approximate Interval Between Onset and Death<br>Seconds<br>Minutes<br>Hours<br>Days |  |   |  |  |   |  |  |  |
| Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1.<br><u>MORBID OBESITY.</u><br><u>POSTMENOPAUSAL BLEEDING</u>   |  |   |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |   |  |  |  |
| 29b. Signature and Title of Certifier<br> Dr. E. Metzger  |  | 29c. License number<br>D17067   |  | 29d. Date signed (Month, Day, Year)<br>4/14/97   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>STEPHEN E. METZGER, MD 747 NINTH AVE HAGERSTOWN, MD  |  |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 16 1997   |  | 32. Registrar's Signature<br>  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12783

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Benjamin MOWEN

2. Date of Death

Month

Day

Year

April

11

1997

7:55 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Ravenwood Lutheran Village

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

220-18-2084

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

January 6, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14150 Fortney Drive

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Waste Management Co.

17. Father's Name (First, Middle, Last)

Alvey Willis Mowen

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Viola Eakle

19a. Informant's Name/Relationship (Type, Print)

Imogene H. Mowen, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14150 Fortney Drive, Hagerstown, Maryland 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Memorial Park

Date

April 14 Hagerstown, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kerry A. Younker

22. Name and Address of Facility

Douglas A. Fiery Funeral Home  
1331 Eastern Blvd. N., Hagerstown, Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Carcinoma of Lungs

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease (COPD)

Dehydration, Undernutrition

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edson Moody

29c. License number

D07857

29d. Date signed (Month, Day, Year)

4/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Edson Moody 1190 Mt. Aetna Rd. Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

APR 14 1997

32. Registrar's Signature

John D. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12784

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |  |  |
|---|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Cecelia Elizabeth MORGAN</b>                         |   |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>11</b> Year <b>1997</b> |  | 3. Time of Death<br><b>3:45 AM</b>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Homewood Retirement Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Williamsport</b>           |  | 4c. County of Death<br><b>WASHINGTON</b>                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-34-0413</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><b>July 3, 1910</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington</b>                                      |  | 10c. City, Town or Location<br><b>Williamsport</b>         |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>16505 Virginia Ave.</b>  |  | 10f. Zip Code<br><b>21795</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business/Industry<br><b>Education</b>   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Arthur Lawton, Sr.</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Littman</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Virginia Lawton</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>30001 Veazey Terrace Apt. 826, NW, Washington, DC 20008</b>                              |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory Apr. 11, 1997</b>   |  | 20c. Location - City or Town, State<br><b>Smithsburg, MD 21783</b>   |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>OSBORNE FUNERAL Home<br/>P.O. Box # 348 Williamsport, MD 21795</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. BRAINSTEM INFARCTION</b><br>Due to (or as a consequence of):<br><b>b. CROHN'S DISEASE</b><br>Due to (or as a consequence of):<br><b>c. ATHEROSCLEROSIS</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |   |  |  |  |
| Approximate Interval Between Onset and Death<br><b>1 Wk. 9 mos. 2 days</b>  |   |   |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ACUTE FIBRILLATION</b><br><b>RECENT CONGESTIVE HEART FAILURE</b>   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and Title of Certifier<br>   |  | 29c. License number<br><b>157067</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/11/97</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>STEPHEN E. MORGAN, MD 777 Northview Ave Hagerstown, Md 21742</b>   |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>   |   | 32. Registrar's Signature<br>   |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

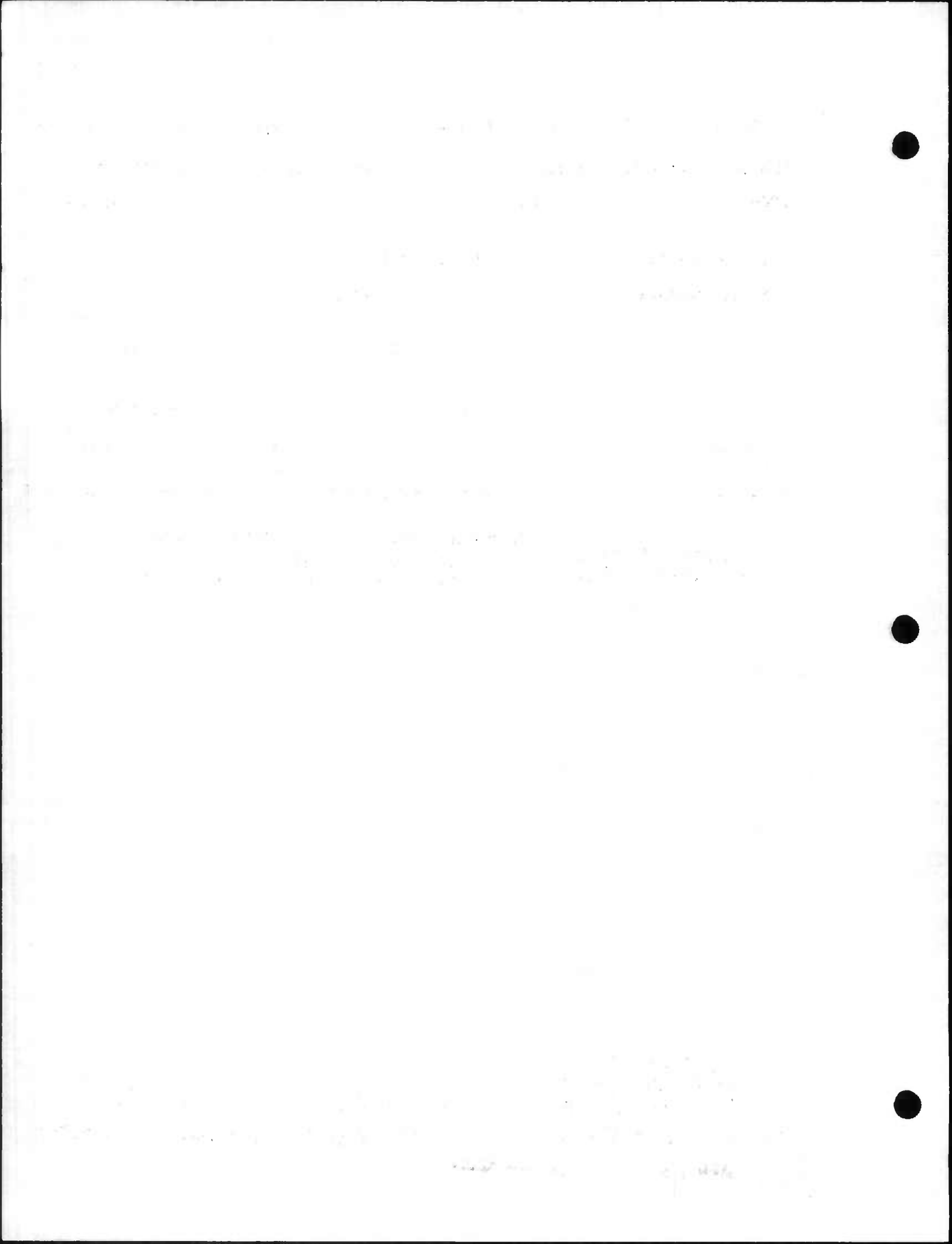
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12785

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIVIAN BERNICE MOODY

2. Date of Death  
Month Day Year

APRIL 9, 1997

3. Time of Death

2:00 A.M.

4a. Facility Name (If not institution, give street and number)

458 PARK PLACE

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

Funeral  
Director

5. Social Security Number

214 14 1964

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

JANUARY 24, 1913 MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

HAGERSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

458 PARK PLACE

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

BEAUTICIAN

16b. Kind of Business/Industry

HAIRDRESSER

17. Father's Name (First, Middle, Last)

CHARLES SUMNER BELL

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET BROWN

19a. Informant's Name/Relationship (Type, Print)

MARGARET E. WASHINGTON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

458 PARK PLACE HAGERSTOWN, MD. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CEDAR HILL CEMETERY 4/15/97 BALTIMORE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Gerald N. Minnich*

22. Name and Address of Facility

GERALD N. MINNICH 305 N. POTOMAC ST.  
FUNERAL HOME HAGERSTOWN, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)e. *Cardio-pulmonary arrest* minutes

Due to (or as a consequence of):

b. *Underlying Cardiovascular Disease* years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Martin W. Ballapher, Jr MD*

29c. License number

D31880

29d. Date Signed (Month, Day, Year)

4/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN W. BALLAPHER, JR MD 1110 MEDICAL CENTER BLVD  
HAGERSTOWN, MD 21740

31. Date filed (Month, Day, Year)

APR 15 1997

32. Registrar's Signature

*John H. ...*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

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Division of Vital Records, P.O. Box 68760,





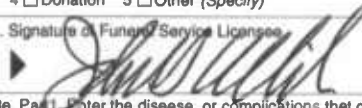
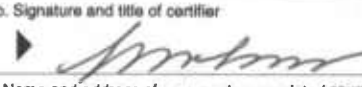
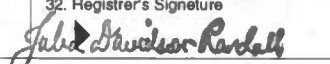


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12786

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN J. MAC CALLUM</b>                                     |  |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>13</b> Year <b>1997</b>      |   |  | 3. Time of Death<br><b>11:37 AM</b>              |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>BERLIN NURSING &amp; REHAB. CTR.</b> |  |   | 4b. City, Town, or Location of Death<br><b>BERLIN</b>                      |   |  | 4c. County of Death<br><b>WORCESTER</b>          |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>208-03-5143</b>   |  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs. |  |  |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>10-16-14</b>  |  |   | 9. Birthplace (State or Foreign Country)<br><b>PA.</b>                     |   |  |  |  |  |  |
| Usual Residence of Decedent  |   |  |   |  |   |  |  |  |  |  |
| 10a. State<br><b>MD.</b>   |   |  | 10b. County<br><b>WORCESTER</b>   |  |   | 10c. City, Town or Location<br><b>OCEAN CITY</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>13334 CONSTITUTIONAL AVE.</b>   |   |  |   |  | 10f. Zip Code<br><b>21842</b>   |  |  | 10g. Citizen of What Country?<br><b>USA</b>                |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SERVICE STATION OWNER</b>   |  |  | 16b. Kind of Business/Industry<br><b>PETROLEUM</b>         |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>J. JAMES MACCALLUM</b>   |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>REA CADUS SCOTT</b>   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MAE. E. MACCALLUM</b>   |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13334 CONSTITUTIONAL AVE. OCEAN CITY, MD.</b>   |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SALISBURY, CREMATORY 4-15</b>  |  |   | 20c. Location - City or Town, State<br><b>SALISBURY, MD.</b>   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  |   |  | 22. Name and Address of Facility<br><b>ULLRICH FUNERAL HOME BERLIN, MD...</b>   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Diffuse Metastatic Disease</b><br>Due to (or as a consequence of):<br>b. <b>Bronchogenic Carcinoma</b><br>Due to (or as a consequence of):<br>c. <b>of Lung</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>17 - 19.</b> |   |  |   |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diffuse Arteriosclerosis - Semilitary.</b>  |   |  |   |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day Year)   |  |   | 28b. Time of Injury<br><b>M</b>  |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |  | 28d. Describe how injury occurred   |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   |  |   |  | 29c. License number<br><b>D02026</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>April 13 97.</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FEDERICO G. ARTES MD 1622A OCEAN PINES BERLIN MD 21811</b>  |   |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>  |   |  |   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12788

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIS MARTENS

2. Date of Death

Month Day Year  
APRIL 5, 1997

3. Time of Death

12:14PM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

217-14-5969

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 12, 1915

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9014 Rhode Island Avenue #407

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Machine Shop

17. Father's Name (First, Middle, Last)

John Martens

18. Mother's Name (First, Middle, Maiden Surname)

Adelia Schumann

19a. Informant's Name/Relationship (Type, Print)

William J. Martens - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7213 Windsor Lane, Hyattsville, Maryland 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

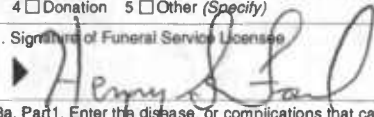
Fort Lincoln Cemetery 04/09/97

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Septic  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 weeks

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. esophagectomy  
Due to (or as a consequence of):

2 weeks

c. esophageal CA  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

P 30318

29d. Date signed (Month, Day, Year)

4/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Catavenis, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature



willis martens

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12789

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AUDREY

2. Date of Death

Month

Day

Year

APRIL

2 1997

3. Time of Death

5:00 pm

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-72-5197

6. Sex

☐ M ☒ F

7. Age (in yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 15, 1933

9. Birthplace (State or Foreign Country)

Trinidad

Usual Residence of Decedent

10a. State

Maryland Prince George's

10b. County

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6008 Belle Court

10f. Zip Code

20782

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Government/Private

17. Father's Name (First, Middle, Last)

Thomas Joseph Hospedales

18. Mother's Name (First, Middle, Maiden Surname)

Maude John

19a. Informant's Name/Relationship (Type, Print)

Lynette Stewart - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

819 Islington Street, Silver Spring, MD 20910

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee's Crematory

Date

4/10/97

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N.E., Washington, D. C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. CANCER OF UTERUS WITH METASTASIS

Due to (or as a consequence of):

d. DIABETES

e. PNEUMONIA AND PULMONARY EDEMA

Approximate Interval Between Onset and Death

6-10 months

8 DAYS

3/26/97

2 months

SEVERAL YEARS

8 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

28. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samuel W. Alleyne

29c. License number

D25766

29d. Date signed (Month, Day, Year)

4/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7100 BALTIMORE AVE #570 COLLEGE PARK, MD 20744

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

John Andrew Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report

is devoted to a general

description of the

method used in the

investigation.

The results of the

experiments are

presented in the

second part of the

report.

The

conclusions are

drawn in the third

part of the report.

The author wishes to

express his appreciation to the

authorities of the

Ministry of

Education and

Science

for their



97 12790

1. Decedent's Name (First, Middle, Last)  
2. Date of Death  
3. Time of Death  
4a. Facility Name (If not institution, give street and number)  
4b. City, Town, or Location of Death  
4c. County of Death  
5. Social Security Number  
6. Sex  
7. Age (In yrs. last birthday)  
8. Date of Birth (Month, Day, Year)  
9. Birthplace (State or Foreign Country)  
10a. State  
10b. County  
10c. City, Town or Location  
10d. Inside City Limits  
10e. Street and Number  
10f. Zip Code  
10g. Citizen of What Country?  
11. Marital Status  
12. Was Decedent Ever in U.S. Armed Forces?  
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
14. Race - American Indian, Black, White, etc.  
15. Decedent's Education (Specify only highest grade completed)  
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
16b. Kind of Business/Industry  
17. Father's Name (First, Middle, Last)  
18. Mother's Name (First, Middle, Maiden Surname)  
19a. Informant's Name/Relationship (Type, Print)  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
20a. Method of Disposition  
20b. Place of Disposition (Name of cemetery, crematory or other place)  
20c. Location - City or Town, State  
21. Signature of Funeral Service Licensee  
22. Name and Address of Facility  
23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
23b. Approximate Interval Between Onset and Death  
24a. Was an autopsy performed?  
24b. Were autopsy findings available prior to completion of cause of death?  
25. Was case referred to medical examiner?  
26. Place of Death (Check only one)  
27. Manner of Death  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury  
28c. Injury at Work?  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)  
29a. Certifier (Check only one)  
29b. Signature and title of certifier  
29c. License number  
29d. Date signed (Month, Day, Year)  
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
31. Date filed (Month, Day, Year)  
32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12791

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Judson Daniel Motley  |  |   |  | 2. Date of Death<br>Month Day Year<br>04 04 97  |  | 3. Time of Death<br>7:05 PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Prince George's Hospital Center   |  |   |  | 4b. City, Town, or Location of Death<br>Cheverly  |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director   | 5. Social Security Number<br>223-46-1397  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>58 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>09 17 1938                                    |  |
|   | 9. Birthplace (State or Foreign Country)<br>Virginia  |  | 10a. State<br>Maryland  |  | 10b. County<br>Prince George's  |  | 10c. City, Town or Location<br>Lanham  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>7916 Dellwood Avenue  |  | 10f. Zip Code<br>20706  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 3/13/64 to 3/14/62  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>College (1-4 or 5+) Metro Driver   |  | 16b. Kind of Business/Industry<br>Private   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Judson Motley  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Minnie Pearl Dixon   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Leola Motley/Wife   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7916 Dellwood Avenue, Lanham, Maryland 20706   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Maryland Veterans Cemetery  |  | 20c. Location - City or Town, State<br>Cheltenham, Maryland   |  | Date<br>04/11 1997   |  |
|   | 21. Signature of Funeral Service Licensee<br>Nancy A. Perentis  |  |   |  | 22. Name and Address of Facility<br>J. B. JENKINS FUNERAL HOME<br>7474 Landover Road, Landover, Maryland 20785  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Congestive Heart Failure<br>Due to (or as a consequence of):<br>Severe Hypertension<br>b. Auricular Fibrillation<br>Due to (or as a consequence of):<br>c. d. 19.05<br>10 Years<br>2 Years |  |   |  |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |   |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br>Richard Perry M.D.   |  |   |  | 29c. License number<br>D09573   |  | 29d. Date signed (Month, Day, Year)<br>04-10-97                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Richard Perry, M.D., 1145 19th Street, NW, Suite #600, Washington, D.C. 20036   |   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 10 1997  |   |  |   | 32. Registrar's Signature<br>John Davidson |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12792

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Magdalen McLaughlin

2. Date of Death

April 12, 1997

3. Time of Death

11:30 pm

4a. Facility Name (If not institution, give street and number)

Mallard Bay Center Genesis ElderCare

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

220-05-9092

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

102

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 12, 1894

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

-

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Westminster Apts.  
Charles & Center Streets

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Unknown Unknown Chance

18. Mother's Name (First, Middle, Maiden Surname)

Mary Virginia Aker

19a. Informant's Name/Relationship (Type, Print)

Mrs. Jean Reed - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3839 Main St., Trappe, MD 21673

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Peter's Cemetery

Date

20c. Location - City or Town, State

4-15-97 Queenstown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.  
308 High St., Cambridge, MD 21613

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Urinary sepsis  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease  
Old age

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-28209

29d. Date signed (Month, Day, Year)

April 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Edmund J. MacLaughlin, 10 Aurora St., Cambridge, MD 21613

31. Date filed (Month, Day, Year)

APR 15 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 12793

DMMH 16 Rev 6/95





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State of Maryland / Department of Health and Mental Hygiene

97 12794

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clement

Vincent

Mitchell

2. Date of Death

April 10, 1997

3. Time of Death

5:30A.

4a. Facility Name (If not institution, give street and number)

62-A Ridge Road

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-05-6954-A

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 3, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

XX Yes 2□ No

10e. Street and Number

62-A Ridge Road

10f. Zip Code

20770

10g. Citizen of What Country?

United States

11. Marital Status

1□ Never Married 2□ Married

3XX Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

XX Yes 2□ No

If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes XX No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Chef

16b. Kind of Business/Industry

Restaurant Industry

17. Father's Name (First, Middle, Last)

John

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Lewis Merritt (stepson)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14J Hillside Road Greenbelt, Maryland 20770

20a. Method of Disposition

XX Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery 4/12/1997

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. MALIGNANT VENTRICULAR ARRHYTHMIA 6 weeks.

Due to (or as a consequence of):

b. CONGESTIVE CARDIOMYOPATHY. I YEAR.

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE 15 years.

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2XX No 3□ Probably 4□ Unknown

24a. Was an autopsy  
performed?

1□ Yes 2XX No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1□ Yes 2XX No

25. Was case referred to medical  
examiner?

1XX Yes 2□ No

26. Place of Death (Check only one)

Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA

Other:

4□ Nursing Home 5XX Residence 6□ Other (Specify)

27. Manner of Death

1XX Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending  
Investigation6□ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1□ Yes 2XX No

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

Asif S. Qadri

29c. License number

D22910

29d. Date signed (Month, Day, Year)

April 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Asif S. Qadri, M.D. 4700 Berwyn House Road College Park, Maryland 20740

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12795

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICIA

P.

MAKAROV

2. Date of Death

Month

Day

Year

APRIL

3

1997

3. Time of Death

8:55A.M.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

054-38-5776

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

December 18, 1931

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10915 Brewer House Road

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16e. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Edward Parkinson

18. Mother's Name (First, Middle, Maiden Surname)

Lucia Depew

19e. Informant's Name/Relationship (Type, Print)

John Makarov / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10915 Brewer House Road, Rockville, Maryland 20852

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Head of River Cemetery

Date

April 10, 1997

20c. Location - City or Town, State

Estelle Manor, NJ

21. Signature of Funeral Service Licensee

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.

300 West Montgomery Avenue, Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. CARCINOMA OF LUNG

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SCHIZOPHRENIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

APRIL 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

HARRINGTON A. KORSEK 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12796

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mina Miranvarian

2. Date of Death

Month Day Year  
APRIL 5 1997

3. Time of Death

0005 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

227-27-1954

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 7, 1943

9. Birthplace (State or Foreign Country)

Iran

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

509 Nelson Street

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Computer Consultant

16b. Kind of Business/Industry  
Montgomery County  
Government

17. Father's Name (First, Middle, Last)

Said Hassan

18. Mother's Name (First, Middle, Maiden Surname)

Tahereh Aghdas Anvari Tehrani

19a. Informant's Name/Relationship (Type, Print)

Arezou K. Palmer/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

509 Nelson Street, Rockville, Maryland 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place) April 7, 1997  
Parklawn Memorial Park

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Michael P. Kutta M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 W. Montgomery Avenue,  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Vancomycin resistant enterococci enteritis  
Due to (or as a consequence of):

3 weeks

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. Staphylococcus aureus  
Due to (or as a consequence of):

3 days

c. Hypertension and stage renal disease  
Due to (or as a consequence of):

9 years

d. Multiple cerebral strokes  
deep vein thrombosis / hypercoagulable state

5 years

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pneumonia

seizure disorders

congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ ODA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Kaldun Nossuli

29c. License number

D23091

29d. Date signed (Month, Day, Year)

April 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kaldun NOSSULI 4915 Auburn Avenue Bethesda MD 20814 - P 301.9074646

State  
Registrar

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12797

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harriet C. Myers

2. Date of Death  
Month Day Year  
April 6, 19973. Time of Death  
2:00 PMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

12713 Hathaway Drive

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

5. Social Security Number

201-07-9844

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 14, 1919

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10e. State

MD

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12713 Hathaway Drive

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Leslie Corbin

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Wiltshire

19a. Informant's Name/Relationship (Type, Print)

Mr. Robert A. Myers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Centerwood Drive, Wilbraham, MA 01095

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

Date

4/10/97

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

William L. Boyd

22. Name and Address of Facility

Francis J. Collins Funeral Home  
500 University Blvd., W., Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pulmonary Failure

Due to (or as a consequence of):

2 mos.

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Metastatic Carcinoma

Due to (or as a consequence of):

2 yrs.

c. Lung Cancer

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28e. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Stanley A. Schwartz, MD

29c. License number

D17368

29d. Date signed (Month, Day, Year)

4/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stanley A. Schwartz, MD 2101 Medical Park Drive, 201 Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

32. Registrar's Signature

APR 08 1997

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
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once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12798

## Certificate of Death

Reg. No.

|   |   |   |   |   |   |  |                                   |  |
|---|---|---|---|---|---|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Agnes S. Monahan                          |   |   |   | 2. Date of Death<br>Month Day Year<br>April 8, 1997   |  | 3. Time of Death<br>2:45AM        |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital |   |   |   | 4b. City, Town, or Location of Death<br>Silver Spring |  | 4c. County of Death<br>Montgomery |  |
| Funeral<br>Director   | 5. Social Security Number<br>207-05-2979  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>82 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth (Month, Day, Year)<br>Dec. 13, 1914   |                                   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |
|   | Usual Residence of Decedent   |   |   |   |   |  |                                   |  |
| 10a. State<br>Maryland  |   | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Rockville  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                   |  |
| 10e. Street and Number<br>4606 Creek Shore Drive  |   |   |   | 10f. Zip Code<br>20852  |   | 10g. Citizen of What Country?<br>United States   |                                   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+)<br>4   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Pharmacist   |   | 16b. Kind of Business/Industry<br>Pharmacy   |                                   |  |
| 17. Father's Name (First, Middle, Last)<br>Thomas A. Shannon  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Agnes Coleman  |   |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Kathleen M. Kenyon/Daughter   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11808 Coldstream Drive, Potomac, Maryland 20854  |   |  |                                   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery   |   | 20c. Location - City or Town, State<br>Silver Spring, MD   |                                   |  |
| 21. Signature of Funeral Service Licensee<br>Daniel E. Perry  |   |   |   | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/<br>Rockville, Inc. 300 West Montgomery Avenue<br>Rockville, Maryland 20850-2805   |   |  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |   |   |  |                                   | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)   |   |   |   |   |   |  |                                   | 2 DAYS   |
| a. SEPSIS<br>Due to (or as a consequence of):   |   |   |   |   |   |  |                                   |  |
| b. PERFORATED GASTRIC ULCER<br>Due to (or as a consequence of):   |   |   |   |   |   |  |                                   | 5 DAYS   |
| c. EXTENSIVE SMALL CELL CARCINOMA OF LUNG<br>Due to (or as a consequence of):   |   |   |   |   |   |  |                                   | 18 MONTHS  |
| d. BONE METASTASES<br>Due to (or as a consequence of):  |   |   |   |   |   |  |                                   | 18 MONTHS  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Atrial Fibrillation<br>Congestive Heart Failure  |   |   |   |   |   |  |                                   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |   |   |   |   |  |                                   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |   |   |  |                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                   | 28d. Describe how injury occurred  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |                                   |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |   |  |                                   |  |
| 29b. Signature and Title of certifier<br>John M. Dunell   |   |   |   | 29c. License number<br>D35996   |   | 29d. Date signed (Month, Day, Year)<br>4-8-97  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>2101 MEDICAL PARK DRIVE #210 SILVER SPRING, MD 20902  |   |   |   |   |   |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>APR 09 1997  |   |   |   | 32. Registrar's Signature<br>John Davidson-Randall  |   |  |                                   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12799

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Chong Guk Mah</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>6</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>6:28 PM</b>   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>19301 Watkins Mill Road</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Gaithersburg</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>215-92-9232</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 2, 1907</b>                       |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Korea</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>North Potomac</b>                              |  |  |
| To Be Completed by Funeral Director           | Usual Residence of Decedent   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |
|   | 10e. Street and Number<br><b>14412 Rich Branch Drive</b>  |  |   |  | 10f. Zip Code<br><b>20878</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                            |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Korean</b>         |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>+4</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Prof. in Chemistry</b>  |  | 16b. Kind of Business/Industry<br><b>Private</b>   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Woo Kap Mah</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eun Joo Yang</b>   |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Choon Ok Rhee/Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14901 Perrywood Drive, Burtonsville, MD 20866</b>  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cem.</b>  |  | Date<br><b>4/8/97</b>  |  | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>                  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home<br/>11800 New Hampshire Ave Silver Spring, MD</b>  |  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Dehydration</b><br>Due to (or as a consequence of):<br><b>b. Electrolyte Imbalance</b><br>Due to (or as a consequence of):<br><b>c. Dementia</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |  |  | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Terminal chronic obstructive lung disease</b>  |  |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |  |
|   | 29b. Signature and Title of certifier<br><i>[Signature]</i> MD  |  |   |  | 29c. License number<br><b>D30692</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 7, 1997</b>                      |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Gabriel A. Berrebi, M.D. 15200 Shady Grove Road, #305, Rockville, Maryland 20850</b>   |  |   |  |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 09 1997</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12800

## Certificate of Death

Reg. No.

6 0/6

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Willie Ben Nathan

2. Date of Death

Month Day Year  
April 3, 1997

3. Time of Death

12:44 PM

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

256-05-2522

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEP 1, 1914

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Prince Georges10c. City, Town or Location  
Temple Hills

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2915 Fairlawn Street

10f. Zip Code

20748

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Shoe Repair

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Ben Nathan

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Terrell

19a. Informant's Name/Relationship (Type, Print)

Basilene Graham Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2834 Ft. Baker Drive S.E. Washington, D.C. 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

4/11/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Ald. Dore Jr.

M859

22. Name and Address of Facility

Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

28d. Describe how Injury occurred

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Charlene Letchford, M.D., Deputy Medical Examiner

29c. License number

D-46419

29d. Date signed (Month, Day, Year)

4/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charlene Letchford, M.D., Deputy Medical Examiner

700 Old Line Center, Suite 100

Waldorf, Maryland 20602

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



97 12801

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Evelyn Antoinette Nee</i>  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 4, 1997   |  | 3. TIME OF DEATH<br>5:07 pm  |  |
| 4. SOCIAL SECURITY NUMBER<br>577-34-0422  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>93 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>June 13, 1903  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Washington, DC   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Sacred Heart Home   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hyattsville  |  | 9c. COUNTY OF DEATH<br>Prince George's   |  |
| 10a. STATE<br>Maryland  |  |  |   | 10b. COUNTY<br>Prince George's  |  | 10c. CITY, TOWN OR LOCATION<br>Hyattsville   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |   |   |  |  |  |
| 10e. STREET AND NUMBER<br>5805 Queens Chapel Road   |  |  |   | 10f. ZIP CODE<br>20782  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4  |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>DC Public School System  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Peter Joseph Nee   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Agnes Lyden   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Antoinette K. Nee - Niece   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5105 Cammack Drive, Bethesda, Maryland 20816   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Olivet Cemetery 04/07/97  |   | 20c. LOCATION — City or Town, State<br>Washington, DC   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Coni Lynn Masch-Mrady</i>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Avenue, Hyattsville, MD   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF): <i>Advanced Senile Dementia</i><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |   |   |  | Approximate Interval Between Onset and Death<br>Days<br>Years  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Atrial F. brillation</i>   |  |  |   |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |   |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURED   |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stephanie Trifoglio</i>   |  |  |   | 29c. LICENSE NUMBER<br>D3793 Y  |  | 29d. DATE SIGNED (Month, Day, Year)<br>4/7/97  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Stephanie Trifoglio MD 7500 Greenway Ctr Drive Greenbelt MD 20770</i>   |  |  |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 09 1997  |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Parkell</i>   |  |  |  |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





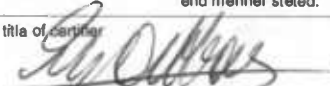
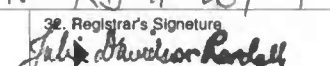
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12802

## Certificate of Death

Reg. No.

|   |   |   |  |   |  |  |   |   |  |
|---|---|---|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Wilford Owen Noel</b>                              |   |  |   | 2. Date of Death<br>Month Day Year<br><b>March 29, 1997</b>    |  | 3. Time of Death<br><b>4:25 a.m.</b>                  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Fort Washington Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Fort Washington</b> |  | 4c. County of Death<br><b>Prince George's</b>         |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>227-42-4886</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.               |  | 8. Date of Birth (Month, Day, Year)<br><b>2/16/35</b> |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>                                       |   | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>PRINCE GEORGE'S</b>                          |  | 10c. City, Town or Location<br><b>CLINTON</b>         |   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>3601 BLACKWATER RD.</b>  |  | 10f. Zip Code<br><b>20735</b>   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+)  |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CLERGY</b>   |  | 16b. Kind of Business/Industry<br><b>PRIVATE</b>  |  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>WILSON NOEL</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE CARTER</b>  |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ROSA NOEL / WIFE</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3601 BLACKWATER RD. CLINTON, MARYLAND 20735</b>   |  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LINCOLN CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>4/5/97 SUITLAND, MARYLAND</b>   |  |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>ALEXANDER S. POPE FUNERAL HOMES</b><br><b>5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747</b>   |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>ACUTE PULMONARY EMBOLUS</b><br>Due to (or as a consequence of):<br>b. <b>CLOSURE OF WOUND DEHISCENCE</b><br>Due to (or as a consequence of):<br>c. <b>LOW ANTERIOR RESECTION</b><br>Due to (or as a consequence of):<br>d. <b>MALIGNANT POLYP RECTO SIGMOID</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |   | Approximate interval Between Onset and Death<br><br><b>1 1/2 DAYS</b><br><br><b>11 DAYS</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
|   |   |   |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |
|   |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>219347</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/2/97</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>11701 LIVINGSTON RD # 201 FT. WASHINGTON MD 20744</b>  |   |   |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1997</b>   |   | 32. Registrar's Signature<br>  |  |   |  |  |   |   |  |

7 1/6

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12803

## Certificate of Death

Reg. No.

|   |   |   |  |   |  |  |  |   |
|---|---|---|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>VERONICA NEVAREZ</b>                             |   |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 3, 1997</b> |  | 3. Time of Death<br><b>3:50 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>N.I.H. CLINICAL CENTER</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>    |  | 4c. County of Death<br><b>MONTGOMERY</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>NONE</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>23</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                             | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 23, 1974</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MEXICO</b>                                 |
|   | Usual Residence of Decedent   |   |  |   |  |  |  |   |
| 10a. State<br><b>TX.</b>  |   | 10b. County<br><b>COLLIN</b>  |  | 10c. City, Town or Location<br><b>PRINCETON</b>   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>8475 C.R. #728</b>   |   | 10f. Zip Code<br><b>75407</b>   |  | 10g. Citizen of What Country?<br><b>MEXICO</b>  |  |  |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <b>MEXICAN</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>HISPANIC</b>   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DOMESTIC ENGINEER</b>   |  |   | 16b. Kind of Business/Industry<br><b>HOME</b>              |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>ANTONIO LOYA</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LYDIA GALAVIZ</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>OMAR NEVAREZ/HUSBAND</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS ITEM #10</b>  |  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PECAN GROVE CEMETERY</b>   |  | Data<br><b>4/7</b>  |  | 20c. Location - City or Town, State<br><b>McKINNEY, TX.</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br> MO0091  |   |   |  | 22. Name and Address of Facility<br><b>CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>X Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>X Pneumonia</b><br>Due to (or as a consequence of):<br><b>X Acidosis</b><br>Due to (or as a consequence of):<br><b>X</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>X</b> |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>imm.</b><br><b>UNK.</b><br><b>UNK.</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |
|   |   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |
|   |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br> (FELLOW)   |  | 29c. License number<br><b>RES-000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-3-97</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>X MARY ANN DEVINE M.D. 9000 ROCKVILLE PIKE BETHESDA, MARYLAND 20892</b>  |   |   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 07 1997</b>   |   | 32. Registrar's Signature<br>  |  |   |  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12804

## Certificate of Death

Reg. No.

|   |   |  |   |                                      |  |   |   |   |  |  |
|---|---|--|---|--------------------------------------|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>CHHORN NHEK</i>  |  |   |                                      | 2. Date of Death<br>Month <i>APRIL</i> Day <i>1</i> Year <i>1997</i>   |   |   |   | 3. Time of Death<br><i>10:29pm</i>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Washington Adventist Hospital</i>  |  |   |                                      | 4b. City, Town, or Location of Death<br><i>Takoma Park</i>   |   |   |   | 4c. County of Death<br><i>Montgomery</i>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>218-08-5944</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><i>79</i> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><i>January 1, 1918</i> |   | 9. Birthplace (State or Foreign Country)<br><i>Cambodia</i>                                    |  |
|   | Usual Residence of Decedent   |  |   |                                      |  |   |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Montgomery</i>  |                                      | 10c. City, Town or Location<br><i>Silver Spring</i>  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><i>1022 quebec Terrace # 302</i>  |  |   |                                      | 10f. Zip Code<br><i>20903</i>  |   | 10g. Citizen of What Country?<br><i>Cambodia</i>              |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>white</i> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i></i>   |  |   |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Farmer</i>   |   |   | 16b. Kind of Business/Industry<br><i>Agriculture</i>                    |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><i>unobtainable</i>  |  |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>unobtainable</i>   |   |   |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Thorn Nhek/ Daughter</i>   |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1022 Quebec Terr. # 302 Silver Spring, MD 20903</i>                                      |   |   |   |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Metropolitan Crematory</i>   |                                      | Date<br><i>Apr. 5, 1997</i>  |   | 20c. Location - City or Town, State<br><i>Alexandria, VA</i>  |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Bryan E. Gulbach</i>  |  |   |                                      | 22. Name and Address of Facility<br><i>Takoma Funeral Home, Inc.<br/>254 Carroll St. NW Washington, DC 20012</i>   |   |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Respiratory Failure</i><br>Due to (or as a consequence of):<br><i>b. Chronic Obstructive Lung Disease</i><br>Due to (or as a consequence of):<br><i>c.</i><br>Due to (or as a consequence of):<br><i>d.</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                      |  |   |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |                                      |  |   |   |   |  |  |
| 23c. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                      |  |   |   |   |  |  |
| 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                      |  |   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Cerebrovascular Accident</i>   |   |  |   |                                      |  |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                      |  |   |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |                                      |  |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)                            |   | 28b. Time of Injury<br>M             |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how Injury occurred                                       |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Antonio G. Uy MD</i> |   | 29c. License number<br><i>D15146</i> |  | 29d. Date signed (Month, Day, Year)<br><i>4/2/97</i>  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>34 University Blvd W. Silver Spring, MD 20901</i>  |   |  |   |                                      |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 09 1997</i>   |   | 32. Registrar's Signature<br><i>Jill Davidson</i>                |   |                                      |  |   |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12805

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph H. Nicholson

2. Date of Death

Month April Day 05 Year 1997

3. Time of Death

0335

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Mary's

5. Social Security Number

579-14-8911

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 3, 1919

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12105 Grandview Avenue

10f. Zip Code

20902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Driver / Dispatcher

16b. Kind of Business/Industry

Taxi Company

17. Father's Name (First, Middle, Last)

Joseph H. Nicholson

18. Mother's Name (First, Middle, Maiden Surname)

Grace C. Worthington

19a. Informant's Name/Relationship (Type, Print)

Dale Edward Nicholson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

George Washington Cemetery 4-9-97

Date

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

Dale E. Nicholson

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE MANY YRS

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dale E. Nicholson Attending

29c. License number

D-44436

29d. Date signed (Month, Day, Year)

April 05 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHVIN KUMAR J. PATEL, 603 POSTOFFICE RD #207 WALDORF MD 20602

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

Julia Davidson-Pondell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12806

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Ilona Osz

2. Date of Death

April 4, 1997

3. Time of Death

2:55 PM

4a. Facility Name (If not institution, give street and number)

10000 Brunswick Avenue, Apt. 412

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

143-32-6507

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 17, 1919

9. Birthplace (State or Foreign Country)

Hungary

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10000 Brunswick Avenue, Apt. 412

10f. Zip Code

20910

10g. Citizen of What Country?

Hungary

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Food Server

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Teres Szucs

19a. Informant's Name/Relationship (Type, Print)

Mary M. Miller

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5503 Glenwood Road, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Oak Cemetery

Date

4-8-97

20c. Location - City or Town, State

Gaithersburg, Maryland

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic breast cancer  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George A. Sidorowicz MD

29c. License number

D43083

29d. Date signed (Month, Day, Year)

April 06, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9707 MEDICAL CENTER DR, #300

ROCKVILLE MD 20850

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12807

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LORNA MARIE OTT</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 5, 1997</b>  |  | 3. Time of Death<br><b>11:30 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Wilson Health Care Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Gaithersburg</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>293-05-9012</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 23, 1918</b>                           |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Gaithersburg</b>                                   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|   | 10e. Street and Number<br><b>401 Russell Avenue, #101</b>   |  |   |  | 10f. Zip Code<br><b>20877</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                                |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Procurement Supervisor</b>            |  | 16b. Kind of Business/Industry<br><b>Navy Exchange</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Walter Paine</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Virginia Hladik</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Janice Magill, Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8224 Brucar Court, Gaithersburg, MD 20877</b>   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>Rockville, Maryland</b>   |  | 20d. Date<br><b>Apr 11, 1997</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home<br/>10 East Deer Park Dr., Gaithersburg, MD 20877</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cancer of Pancreas - Metastatic</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                               |   |  |   |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury et Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br><b>Douglas R. Shumaker, MD</b>   |  | 29c. License number<br><b>227301</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 6, 1997</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DOUGLAS R. SHUMAKER, MD<br/>615 W. MONTGOMERY AVE.<br/>ROCKVILLE, MD 20850</b> |   |  |   |  |   |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>APR 08 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12808

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |   |
|---|---|--|---|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Eleanor Poole</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>9</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>9:35pm</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sykesville Eldercare Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Sykesville</b>   |  | 4c. County of Death<br><b>Carroll County</b>   |   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217-28-1953</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 3, 1930</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent   |  |   |  |   |  |  |   |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Sykesville</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>6159 C Timdan Court</b>  |  |   |  | 10f. Zip Code<br><b>21784</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dietary worker</b>                    |  | 16b. Kind of Business/Industry<br><b>Springfield Hospital</b>   |  |  |   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Floyd Redmond</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>   |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Maybush</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 322 Woodbine MD 21797</b>  |  |  |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>True Gospel Cemetery</b>   |  | Date<br><b>4/12/97</b>  | 20c. Location - City or Town, State<br><b>Lisbon, MD</b> |  |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Brian L. Haight</b>   |  |   |  | 22. Name and Address of Facility<br><b>Haight Funeral Home<br/>P.O. Box 195 Sykesville MD 21784</b>   |  |  |   |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death line.  |  |   |  |   |  |  | Approximate Interval Between Onset and Death                |
|   | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Ovarian Carcinoma</b><br>Due to (or as a consequence of):  |  |   |  |   |  |  | <b>Five Years</b>   |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.  |  |   |  |   |  |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |   |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |   |  |  |   |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |   |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  |  |   |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |   |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |  |   |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |   |  |  |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |   |
| State Registrar                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |  |  |   |
|   | 29b. Signature and title of certifier<br><b>[Signature] MD</b>  |  |   |  | 29c. License number<br><b>D33184</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 10, 1997</b>                                       |   |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Jonathan D. Kushner 114 Business Center Drive Beltsville, MD</b>   |  |   |  |   |  |  |   |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>   |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



97 12809

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Herbert Franklin Price</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>April</i> DAY <i>14</i> YEAR <i>1997</i>   |  | 3. TIME OF DEATH<br><i>12:54 P. M.</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>213-58-9661</i>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>45</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Feb. 25, 1952</i>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>115 Rachels Court</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Smithsburg</i>  |  | 9c. COUNTY OF DEATH<br><i>Washington</i>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><i>Md.</i>   |  | 10b. COUNTY<br><i>Washington</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Smithsburg</i>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>115 Rachels Court</i>   |  |  |  | 10f. ZIP CODE<br><i>21783</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (9-12)</i>   |  | 15b. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Equipment Operator</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Road Dept.</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Benjamin E. Price</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Bessie Jane Norwood</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Frances E. Price (Wife)</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>115 Rachels Court Smithsburg, Md. 21783</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Smithsburg Crematory Apr. 15, 97</i>   |  | DATE<br><i>Apr. 15, 97</i>  |  | 20c. LOCATION — City or Town, State<br><i>Smithsburg, Md.</i>                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Thomas L. Davis</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Gun Shot Wound To Head</i>  |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Arthur H. Horn M.D. Asst Deputy Medical Examiner</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>OCMB</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>April 14, 1997</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Arthur H. Horn M.D. 818 Virginia Ave. Hagerstown, Md. 21740</i>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>APR 22 1997</i>  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12810

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Ruth Augusta Powell   |  |  |  | 2. Date of Death<br>Month: April Day: 13 Year: 1997  |  |  |  | 3. Time of Death<br>20:55  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital  |  |  |  | 4b. City, Town, or Location of Death<br>Hagerstown   |  |  |  | 4c. County of Death<br>Washington  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>220-16-3592  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>77 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>June 24, 1919 |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent   |  |  |  | 10a. State<br>Maryland   |  | 10b. County<br>Washington                            |  | 10c. City, Town or Location<br>Hagerstown  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br>12808 Oak Hill Avenue Apt. 15  |  |  |  | 10f. Zip Code<br>21742   |  |
|   | 10g. Citizen of What Country?<br>USA  |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+)   |  |
|   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>custodian   |  |  |  | 16b. Kind of Business/Industry<br>school   |  |  |  | 17. Father's Name (First, Middle, Last)<br>Willie Thomas   |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br>Grace Knodler  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Richard D. Powell  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12808 Oak Hill Avenue Hagerstown, Maryland  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Memorial Cedar Lawn Park   |  |  |  | 20c. Location - City or Town, State<br>4/16/97 Hagerstown, Md.   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Gerald N. Minnich  |  |  |  | 22. Name and Address of Facility<br>Gerald N. Minnich 305 N. Potomac Street<br>Funeral Home Hagerstown, Maryland   |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Atherosclerotic heart disease<br>Due to (or as a consequence of):<br>b. Hyperlipidemia<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |
|   | 28a. Date of Injury (Month, Day, Year)  |  |  |  | 28b. Time of Injury<br>M   |  |  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 29b. Signature and title of certifier<br>Martha A. P. Rogers MD  |  |  |  | 29c. License number<br>D38968  |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br>4/18/97  |  |  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>1110 Medical Campus Rd. Suite 107 Hagerstown, MD 21742   |  |  |  | 31. Date filed (Month, Day, Year)<br>APR 18 1997   |  |
|   | 32. Registrar's Signature<br>Julia Anderson   |  |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

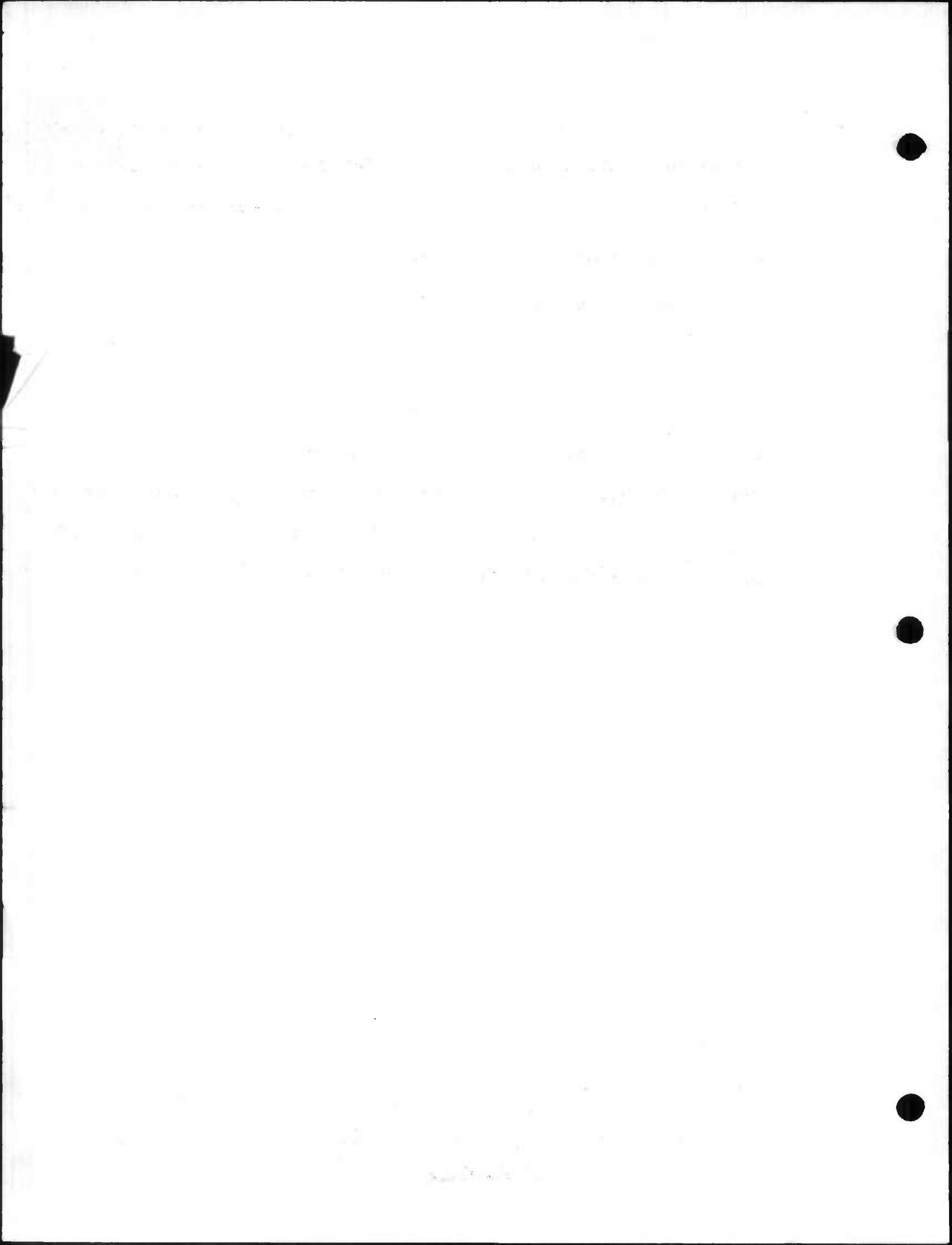
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12811

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Dolores Virginia POLLEY</b>   |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>12</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>16:19</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |  | 4c. County of Death<br><b>Washington</b>  |  |
| 5. Social Security Number<br><b>220-80-7328</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>January 25, 1941</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Washington</b>   |  | 10c. City, Town or Location<br><b>Williamsport</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>15446 Falling Waters Rd.</b>   |  | 10f. Zip Code<br><b>21795</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  | 16b. Kind of Business/Industry<br><b>Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>John Calvin McKinsey</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen May Boyer</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Lee Polley, Sr./Husband</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15446 Falling Waters Rd. Williamsport, MD 21795</b>                                      |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenlawn Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>Williamsport, MD</b>  |  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795</b>   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Carcinoma of lung</b>   |  | Due to (or as a consequence of):<br>a. <b>Carcinoma of lung</b><br>b.<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>8 months</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive lung disease</b>                            |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                          |  | 28a. Date of Injury (Month, Day, Year)<br><b>April 12 1997</b>   |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D 23823</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/14/97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. F. H. Kass 11110 Medical Campus Rd. Hagerstown, Md. 21742</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>   |  | 32. Registrar's Signature<br>  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12812

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>HERBERT C. POWELL  |  |   |  | 2. Date of Death<br>Month Day Year<br>04 04 1997   |  | 3. Time of Death<br>1:06 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Prince George's Hospital Center  |  |   |  | 4b. City, Town, or Location of Death<br>Cheverly   |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>579-76-8324   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>39 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>07-07-1957  |  |
|   | 9. Birthplace (State or Foreign Country)<br>South Carolina   |  | 10a. State<br>Maryland  |  | 10b. County<br>Prince George's   |  | 10c. City, Town or Location<br>Landover  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>1105 Capitol View Drive, #321   |  | 10f. Zip Code<br>20785   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cook   |  | 16b. Kind of Business/Industry<br>Private  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Herbert Powell  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Vermelle L. Brunson   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Theresa R. Powell/Wife   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1105 Capitol View Dr, #321, Landover, MD 20785  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |  | Date<br>04/07 1997   |  | 20c. Location - City or Town, State<br>Beltsville, Maryland  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Nancy A. Perentie   |  |   |  | 22. Name and Address of Facility<br>J. B. JENKINS FUNERAL HOME<br>7474 Landover Road, Landover, Maryland 20785   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. acute myocardial infarction<br>Due to (or as a consequence of):<br>b. acute cerebrovascular accident<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |  |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>Barry Rosenberg MD  |  |   |  | 29c. License number<br>D09776  |  | 29d. Date signed (Month, Day, Year)<br>4/6/97  |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>BARRY ROSENBERG MD 6501 LANDOVER RD CHEVERLY, MD 20785   |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>APR 07 1997   |  |   |  | 32. Registrar's Signature<br>John A. Randall   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 12813

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evangeline Pararas

2. Date of Death  
Month Day Year

April 3, 1997

3. Time of Death

6:15 AM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

579-14-2001

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 8, 1915

9. Birthplace (State or Foreign Country)

Greece

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

199 Rollins Avenue #521

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Leonidas Pararas

18. Mother's Name (First, Middle, Maiden Surname)

Ouriana Lambadakis

19a. Informant's Name/Relationship (Type, Print)

John L. Pararas/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

638 Crocus Drive, Rockville, Maryland 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

April 4, 1997

Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Ray Faulk

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.

300 West Montgomery Avenue

Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Aortic Stenosis

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d. Hyperlipidemia

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John E. Kelly M.D.

29c. License number

D06349

29d. Date signed (Month, Day, Year)

April 3, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John E. Kelly, M.D. 2401 Research Blvd., Suite 340, Rockville, MD 20850

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

John Davidson-Rendall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12814

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DALE

G.

PAYNE

2. Date of Death

Month

Day

Year

March 26, 1997

3. Time of Death

6:15 A

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

213-24-3722

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2-7-29

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

W. Va.

10b. County

Morgan

10c. City, Town or Location

Paw Paw

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P. O. Box 37

10f. Zip Code

25434

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1951-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Security

16b. Kind of Business/Industry

Giant Food

17. Father's Name (First, Middle, Last)

William Payne

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Butts

19a. Informant's Name/Relationship (Type, Print)

Charmaine B. Payne (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box 37 Paw Paw, W. Va. 25434

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cumberland Crematory

Date

4-1-97

20c. Location - City or Town, State

Cumberland, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Miller Funeral Homes, Inc.

Winchester and Lee Streets Paw Paw, W. Va. 25434

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ADVANCED ESOPHAGEAL CARCINOMA

5/1996

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 23371

29d. Date signed (Month, Day, Year)

March 27 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Q. Zaman Johnson Heights Medical Bldg. Cumberland, MD 21502

31. Date filed (Month, Day, Year)

APR 16 1997

32. Registrar's Signature

John Madison Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
505.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12815

## Certificate of Death

Reg. No.

|  |  |  |   |   |  |                          |                                |   |  |  |
|--|--|--|---|---|--|--------------------------|--------------------------------|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Shirley Brooks ROBISON   |  |   |   | 2. Date of Death<br>Month Day Year<br>April 13, 1997   |                          |                                |   | 3. Time of Death<br>2:59 a.m.  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>743 Guilford Avenue  |  |   |   | 4b. City, Town, or Location of Death<br>Hagerstown   |                          |                                |   | 4c. County of Death<br>Washington  |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-32-4595   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>61 Yrs.  |                          | If Under 1 Year<br>Months Days |   | If Under 24 Hrs.<br>Hours Min.   |  |
|  | 8. Date of Birth<br>(Month, Day, Year)<br>November 5, 1935   |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |   | Usual Residence of Decedent  |                          |                                |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   |  | 10b. County<br>Washington   |   | 10c. City, Town or Location<br>Hagerstown  |                          |                                |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br>743 Guilford Avenue  |  |   |   | 10f. Zip Code<br>21740   |                          |                                |   | 10g. Citizen of What Country?<br>U.S.A.  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |                          |                                |   | 14. Race - American Indian, Black, White, etc.<br>Specify: white                               |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 0  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>housewife   |                          |                                |   | 16b. Kind of Business/Industry<br>own home   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Vernon Brooks Heil, Sr.   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ruby Jane   |                          |                                |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Mr. James Robison/ Husband   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>743 Guilford Avenue, Hagerstown, Maryland 21740   |                          |                                |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rose Hill Cemetery   |                          | Date<br>April 16, 1997         |   | 20c. Location - City or Town, State<br>Hagerstown, Maryland                                    |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Scott M. Minnich</i>   |  |   |   | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 East Wilson Blvd., Hagerstown, Maryland 21740  |                          |                                |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Renal Cell CARCINOMA<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |   | Approximate Interval Between Onset and Death<br>11 years   |                          |                                |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                          |                                |   |  |  |
|  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                          |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                          |                                |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
|  |  |  |   | 28d. Describe how injury occurred   |  |                          |                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   | 29b. Signature and title of certifier<br><i>Ann T. Deh</i>  |  |                          |                                | 29c. License number<br>026523   |  |  |
|  |  |  |   | 29d. Date signed (Month, Day, Year)<br>April 14, 1997   |  |                          |                                |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>DINO J. Delaportasho 1110 Medical Center Road, Hagerstown, MD 21742  |  |  |   |   |  |                          |                                |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 15 1997   |  |  |   | 32. Registrar's Signature<br><i>Juli Shuster</i>  |  |                          |                                |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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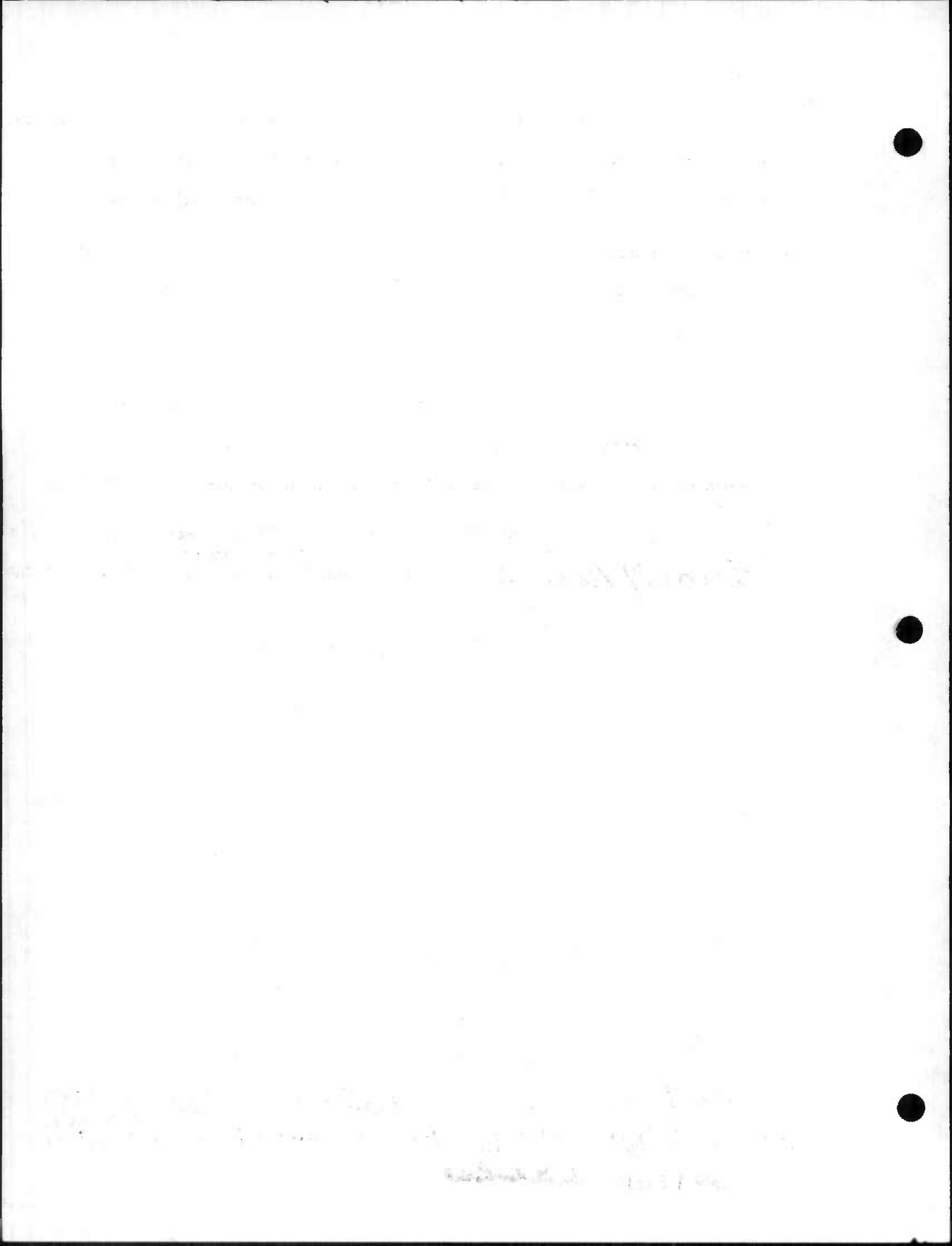
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12816

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence Roland

2. Date of Death  
Month Day Year

4/4/97

3. Time of Death

2:40 PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

UNKNOWN

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

4-24-34

9. Birthplace (State or Foreign Country)

WASHINGTON, D.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

MT. RAINIER

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2405 ARUNDEL RD.

10f. Zip Code

20712

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th GRADE

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CONSTRUCTION WORKER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

HORACE ROLAND

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH FOWLER

19a. Informant's Name/Relationship (Type, Print)

DOROTHEA MOBLEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2424 17th ST. N.W. APT. 103 W.D.C. 20009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HARMONY MEMORIAL PARK 4/12/97

Date

20c. Location - City or Town, State

LANDOVER, MD.

21. Signature of Funeral Service Licensee

Belva J. Jenkins

22. Name and Address of Facility

JOHNSON &amp; JENKINS INC.

716 KENNEDY ST. N.W. W.D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28e. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Z. Bahadori

29c. License number

DYA28

29d. Date signed (Month, Day, Year)

4/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Z. Bahadori

PGHC

Cheverly, MD

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

John A. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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2023

2024 2025

97 12817

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>VICTOR CLARK ROBINSON  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>April 13, 1997  |  | 3. TIME OF DEATH<br>6:35 A.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>217 - 16- 2599  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>January 1, 1922  |  |
| 8. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  | 9c. COUNTY OF DEATH<br>Washington   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Washington   |  | 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>15632 National Pike  |  |  |  | 10f. ZIP CODE<br>21740  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>1943-1946  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>2  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Sheet Metal Worker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Aircraft Mfg.   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>ROY MCKINLEY ROBINSON   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>CHARLOTTE MAE CLARK  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Arlene K. Robinson   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>15632 National Pike, Hagerstown, MD 21740  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Paul's Cemetery 04-17-97 Clear Spring, Maryland   |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>R. Neil Brady   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Andrew K. Coffman Funeral Home, Inc.<br>40 East Antietam Street, Hagerstown, Md. 21740  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. Bilateral Pneumonia<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
|  |  | b. Bilateral Pulmonary Contusions<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | c. Multiple Trauma<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
|  |  | d.   |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Coronary Artery Disease - Status Post Bypass<br>Melanoma - status post resection<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>March 20, 1997   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                 |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>struck by motor vehicle   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>driveway at home  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>15632 National Pike, Hagerstown |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Edward W. Ditto, III, M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D01062   |  | 29d. DATE SIGNED (Month, Day, Year)<br>April 16, 1997   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print)<br>Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, Md 21740   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>APR 17 1997   |  | 32. REGISTRAR'S SIGNATURE<br>John Anderson   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12818

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>HAZEL MARIE ROBINSON</b>  |  |  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>6</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>6:53 P.M.</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>   |  | 4c. County of Death<br><b>ALLEGANY</b>  |  |
| 5. Social Security Number<br><b>220-10-7744</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  |  | 8. Date of Birth<br>Month <b>Sep</b> Day <b>4</b> Year <b>1914</b>  |  |
| 9. Birthplace (State or Foreign)<br><b>PA</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Cumberland</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>1002 Grant Street</b>   |  | 10f. Zip Code<br><b>21502</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Ruben Landis</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine (nmn)</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Edward L. Robinson--son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>128A Canyon Mobile Home Pk; Morgantown, WV 26505</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park</b>  |  | 20c. Date<br><b>04/09</b>  |  | 20d. Location - City or Town, State<br><b>Cumberland, MD</b>  |  | 21. Signature of Funeral Service Licensee<br>   |  |
| 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Carcinomatosis</b><br>Due to (or as a consequence of):<br>b. <b>CA of uterus</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br>a. <b>&gt; one month</b><br>b. <b>&gt; one year</b>   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br><b>April 10, 1997</b>   |  |
| 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 16041</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>April 10, 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Terry Williams M.D. Memorial Hospital Medical Bldg., Cumberland MD 21502</b>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 11 1997</b>   |  | 32. Registrar's Signature<br>  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6  
msState  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12819

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |   |  |   |  |
|---|---|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ESTELLA VIRGINIA RUCKMAN</b>   |   |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>9</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>3:15 A.M.</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |   | 4c. County of Death<br><b>ALLEGANY</b>   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>232-76-1123</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.  | If Under 1 Year<br>Months                        | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br><b>FEB 27, 1905</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |  |
|   | Usual Residence of Decedent   |   |   |  |  |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Allegany</b>  |   | 10c. City, Town or Location<br><b>Cumberland</b> |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|   | 10e. Street and Number<br><b>103 Wills Creek Avenue</b>   |   |   | 10f. Zip Code<br><b>21502</b>                    |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>NEN</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susan (Gray) Frantz</b>  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard L. Ruckman-son</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Wiley Ford WV 26767</b>  |   |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Zion Memorial Park</b>   |  | Date<br><b>04/12</b>   |   | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>   |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>James J. Scarpelli</b>  |   |   |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>   |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Intractable CHF</b><br>Due to (or as a consequence of):<br>b. <b>Dilated Cardiomyopathy</b><br>Due to (or as a consequence of):<br>c. <b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Approximate Interval Between Onset and Death<br><b>4 Months</b><br><b>2 Years</b><br><b>30 Years</b> |   |   |  |  |   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Oldage, Renal Insufficiency</b>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                         |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                     |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>N.A. Ranjithan</b>  |   |   |   | 29c. License number<br><b>D 19318</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>APR 12 1997</b>                                   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>N. Ranjithan M.D. 517 Oldtown Road Cumberland, MD 21502</b>  |   |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 14 1997</b>   |   |   |   | 32. Registrar's Signature<br><b>Jabir...</b>     |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12  
PMS

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12820

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT H. RANDALL, JR.

2. Date of Death

Month Day Year  
APRIL 9, 1997

3. Time of Death

14:50

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

577 20 1705

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 22 1918

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10e. State

Maryland

10b. County

Calvert

10c. City, Town or Location

St. Leonard

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2207 Garrity Road

10f. Zip Code

20685

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Date WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Oceanography

17. Father's Name (First, Middle, Last)

Robert H. Randall

18. Mother's Name (First, Middle, Maiden Surname)

Maree Gard

19a. Informant's Name/Relationship (Type, Print)

Dulcie T. Randall - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2207 Garrity Road St. Leonard, Maryland 20685

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory April 10 1997

Date

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

B. Bausch

22. Name and Address of Facility

Rausch Funeral Home PA

4405 Broomes Is. Rd. Port Republic Maryland 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)e. Intracerebral Hemorrhage  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 day

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert J. Schlager M.D.

29c. License number

D16823

29d. Date signed (Month, Day, Year)

4-10-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERT J. SCHLAGER, M.D.

PRINCE FREDERICK, MD

20678

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12821

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANK A. REEDY

2. Date of Death

Month Day Year  
APRIL 6, 1997

3. Time of Death

8:05PM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

220-28-7496

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 27, 1932

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3004 Newton Street

10f. Zip Code

20902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

Korean Conflict

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Montgomery County Government

17. Father's Name (First, Middle, Last)

Apostle Paul Reedy

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Elizabeth Hopkins

19a. Informant's Name/Relationship (Type, Print)

Frankie Rose Reedy Shawyer/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Route 4, Box 39-M, Hedgesville, West Virginia 25427

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

April 11, 1997

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

David E. Perry

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/

Rockville, Inc. 300 West Montgomery Avenue

Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multiple Injuries

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☒ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

4/6/97

28b. Time of Injury

1030 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

roadway

28d. Describe how injury occurred

Subject

pedestrian struck by vehicle +

pinned between vehicle +

Connecticut Avenue

and Adam Place Montgomery County Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore H. King

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

APRIL 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

THE DOPE M. King

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

40 + 1





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State of Maryland / Department of Health and Mental Hygiene 97 12822

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |                                |  |  |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Elinor Robertson</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>5</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>11:00 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Randolph Hills Nursing Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Wheaton</b>   |                                | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>213-44-5392</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>September 3, 1921</b>  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b> |
| Usual Residence of Decedent  |  |   |  |  |                                |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Wheaton</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>4011 Randolph Road</b>  |  |   |  | 10f. Zip Code<br><b>20902</b>  |                                | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housekeeper</b>  |                                | 16b. Kind of Business/Industry<br><b>Private Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thomas Robertson</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kathleen (Unavailable)</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Suzanne C. Lord</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5630 Fishers Lane, Rockville, Maryland 20852</b>   |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland National Memorial Park 4-8-97</b>   |  | Date<br><b>Laurel, Maryland</b>  |                                | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Rapp Funeral Services, P.A.<br/>933 Gist Avenue, Silver Spring, Maryland 20910</b>  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                                |  |  |
| Approximate Interval Between Onset and Death<br><b>6 hours</b>   |  |   |  |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Protein Calorie Malnutrition</b>  |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  |  | 28d. Describe how Injury occurred   |  |  |                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D09349</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>April 7, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Barry N. Rosenbaum, M.D., 3720 Farragut Avenue, Kensington, Maryland 20895-2110</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1997</b>  |  |   |  | 32. Registrar's Signature<br>   |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12823

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William George Rossignol

2. Date of Death

Month Day Year  
April 4, 1997

3. Time of Death

2:45 AM

4a. Facility Name (If not institution, give street and number)

Sunrise Village House

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

577-07-8613

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 6, 1915

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

108 Fleetwood Terrace

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Switchboard Technician

16b. Kind of Business/Industry

AT&amp;T

17. Father's Name (First, Middle, Last)

Aaron Ethan Rossignol

18. Mother's Name (First, Middle, Maiden Surname)

Emma Douglas

19a. Informant's Name/Relationship (Type, Print)

Robert E. Parkhurst

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20409 Greenfield Road Germantown, Maryland 20876

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

George Washington Cemetery

Date

04/07/97

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

Kevin Gutowski

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. congestive heart failure

Due to (or as a consequence of):

20 years

b. atherosclerotic heart disease

Due to (or as a consequence of):

decades

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cheryl Winchell M.D.

29c. License number

D14555

29d. Date signed (Month, Day, Year)

April 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cheryl Winchell 19241 Montgomery Village Ave. Gaithersburg MD

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

30



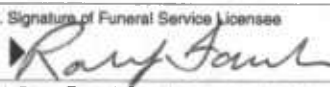

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 12824

Reg. No.

|   |   |   |   |   |   |  |  |   |
|---|---|---|---|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Mildred A. Rourke                                 |   |   |   | 2. Date of Death<br>Month Day Year<br>April 2, 1997 |  | 3. Time of Death<br>2:51 PM  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Montgomery General Hospital |   |   |   | 4b. City, Town, or Location of Death<br>Olney       |  | 4c. County of Death<br>Montgomery  |   |
| Funeral<br>Director   | 5. Social Security Number<br>070-01-2374  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>86 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                      | 8. Date of Birth<br>(Month, Day, Year)<br>Nov. 1, 1910   | 9. Birthplace (State or Foreign Country)<br>New York   |   |
|   | Usual Residence of Decedent   |   |   |   |   |  |  |   |
| 10a. State<br>Maryland  |   | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Silver Spring  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
| 10a. Street and Number<br>3153 Adderley Court   |   |   | 10f. Zip Code<br>20906  |   |   | 10g. Citizen of What Country?<br>United States   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Procurement Agent  |   |  | 16b. Kind of Business/Industry<br>Federal Government   |   |
| 17. Father's Name (First, Middle, Last)<br>Delbert Sylvanus Adsit   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Gwendolyn Edwards  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Dennis J. Rourke/Son  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10416 Gary Road, Potomac, Maryland 20854   |   |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery |   | Date<br>April 5, 1997                               |  | 20c. Location - City or Town, State<br>Silver Spring, MD   |   |
| 21. Signature of Funeral Service Licensee<br> M00198  |   |   |   | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/Rockville, Inc.<br>300 West Montgomery Avenue<br>Rockville, Maryland 20850-2805   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. CHF - Endstage<br>Due to (or as a consequence of):<br>b. CAD<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |   |   |   |  |  | Approximate Interval Between Onset and Death<br>days<br>years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Renal failure 2° decreased cardiac output; NIDDM  |   |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |   |   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                             |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br>043202   |   | 29d. Date signed (Month, Day, Year)<br>April 2, 1997   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>C. Ozanne - Blankland MD 3305 North Leisure world Blvd Silver Spring Maryland 20906   |   |   |   |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>APR 07 1997  |   | 32. Registrar's Signature<br>Julia Davidson-Rendell   |   |   |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



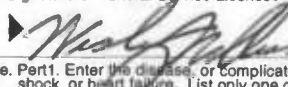
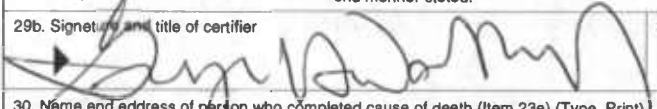
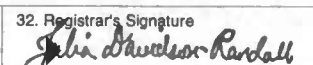
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12825

## Certificate of Death

Reg. No.

|  |   |  |  |                                |  |
|--|---|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Leo Harland Riley</b>  |  | 2. Date of Death<br>Month <b>April</b> Day <b>14</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>8:30pm</b>  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Physicians Memorial Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Ia Plata</b>  |                                | 4c. County of Death<br><b>Charles</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-28-0846</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>September 2, 1923</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |                                |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  | 10a. State<br><b>Maryland</b>  |                                | 10b. County<br><b>Charles</b>  |
|  | 10c. City, Town or Location<br><b>Indian Head,</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                |  |
|  | 10e. Street and Number<br><b>67 Circle Ave.</b>   |  | 10f. Zip Code<br><b>20640</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-1945</b> |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                       |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supply Dept. Supervisor</b>  |
|  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Carroll Riley</b>  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Carroll</b>  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Gladys Josephine Riley</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as #10</b>  |                                |  |
|  | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Charles Cemetery</b>  |                                | Date<br><b>April 17, 1997</b>  |
|  | 20c. Location - City or Town, State<br><b>Indian Head, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br> <b>M00668</b>                      |                                | 22. Name and Address of Facility<br><b>Williams Funeral Home, P.A.<br/>4270 Hawthorne Rd., Indian Head, Maryland 20640</b>   |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Chronic Obstructive Pulmonary Disease</b><br>Due to (or as a consequence of):<br><b>Pharyngeal Cancer (supra glottic)</b><br>Due to (or as a consequence of):<br><b>Diabetes Mellitus</b><br>Due to (or as a consequence of): |  |  |                                |  |
| 23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |  |                                |  |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   |  |  |                                |  |
| 28e. Date of Injury (Month, Day, Year)   |   |  |  |                                |  |
| 28b. Time of Injury<br><b>M</b>  |   |  |  |                                |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |                                |  |
| 28d. Describe how injury occurred  |   |  |  |                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |                                |  |
| 29b. Signature and title of certifier<br>   |   |  |  |                                |  |
| 29c. License number<br><b>D-20629</b>  |   |  |  |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>4/15/97</b>  |   |  |  |                                |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>George Wathen, MD 11345 Penbrooke Square, Suite 103, Waldorf, Maryland 20603</b>  |   |  |  |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 17 1997</b>  |   |  |  |                                |  |
| 32. Registrar's Signature<br>   |   |  |  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12826

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |                                |   |  |  |  |
|---|---|--|---|--|---|--------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CARL JACOB RASNIC</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 15, 1997</b>   |                                | 3. Time of Death<br><b>6:45 PM</b>  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>WILLIAM HILL HEALTH CARE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>EASTON</b>   |                                | 4c. County of Death<br><b>TALBOT</b>  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>224-24-7478</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>JULY 14, 1922</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>                                    |  |
|   | Usual Residence of Decedent   |  |   |  |   |                                |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>TALBOT</b>  |  | 10c. City, Town or Location<br><b>EASTON</b>  |                                |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>501 DUTCHMAN'S LANE</b>  |  |   |  | 10f. Zip Code<br><b>21601</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PROFESSIONAL</b>  |                                | 16b. Kind of Business/Industry<br><b>GOLF</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JACKSON RASNIC</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CORDIELLA ROBINETTE</b>   |                                |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>R. SCOTT PEIRCE</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>29651 DUTCHMAN'S LANE, EASTON, MD 21601</b>   |                                |   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SPRING HILL CEMETERY</b>   |  | Data<br><b>4-18</b>   |                                | 20c. Location - City or Town, State<br><b>EASTON, MD</b>                                    |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>JOHN R. MERCER</b>  |  |   |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD 21601</b>  |                                |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Coronary Vascular Disease</b><br>Due to (or as a consequence of):<br><b>Hypertension</b><br>Due to (or as a consequence of):<br><b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br><b>Chronic Kidney Disease</b><br>Due to (or as a consequence of):<br><b>Obesity</b><br>Due to (or as a consequence of):<br><b>Smoking</b><br>Due to (or as a consequence of):<br><b>Alcohol Abuse</b><br>Due to (or as a consequence of):<br><b>Stress</b><br>Due to (or as a consequence of):<br><b>Family History</b><br>Due to (or as a consequence of):<br><b>Age</b><br>Due to (or as a consequence of):<br><b>Unknown</b> |  |   |  |   |                                |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |   |                                |   |  |  |  |
| 23c. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                   |   |  |   |  |   |                                |   |  |  |  |
| 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |   |  |   |                                |   |  |  |  |
| Physician<br>/Medical<br>Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |                                |   |  |  |  |
| State Registrar   | 29b. Signature and title of certifier<br><b>John R. Mercer</b>  |  |   |  | 29c. License number<br><b>D11308</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>4-16-97</b>                                       |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>R. LANE WROTH, M.D., P.O. BOX 290, ST. MICHAELS, MD 21663</b>  |  |   |  |   |                                |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 17 1997</b>   |   | 32. Registrar's Signature<br><b>John R. Mercer</b> |   |  |   |                                |   |  |  |  |

Baltimore, Maryland 21215-0020  
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12827

## Certificate of Death

Reg. No.

|  |   |  |   |   |  |  |  |  |  |  |
|--|---|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>EVELYN H. RIECK   |  |   |   | 2. Date of Death<br>Month Day Year<br>APRIL 10, 1997   |  |  |  | 3. Time of Death<br>8:05 PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>CAROLINE NURSING HOME   |  |   |   | 4b. City, Town, or Location of Death<br>DENTON   |  |  |  | 4c. County of Death<br>CAROLINE  |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-14-2246  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>82 Yrs. | 8. Data of Birth (Month, Day, Year)<br>DEC. 25, 1914   | 9. Birthplace (State or Foreign Country)<br>MARYLAND |  |  |  |  |
|  | Usual Residence of Decedent   |  |   |   |  |  |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD  |  | 10b. County<br>TALBOT   |   | 10c. City, Town or Location<br>EASTON  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  | 10e. Street and Number<br>7295 OCEAN GATEWAY  |  |   |   | 10f. Zip Code<br>21601   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                     |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOUSEWIFE  |   | 16b. Kind of Business/Industry<br>OWN HOME   |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>WRIGHT P. HARRIS   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>REBA CHANCE   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>LEONARD H. RIECK/HUSBAND  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7295 OCEAN GATEWAY, EASTON, MD 21601  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>WOODLAWN MEMORIAL PARK 4-14   |   | 20c. Location - City or Town, State<br>EASTON, MD  |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>JOHN R. MERCERON CFSP  |  |   |   | 22. Name and Address of Facility<br>FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME<br>200 S. HARRISON ST., EASTON, MD 21601   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. PNEUMONIA<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |   |  |  |  |  | Approximate Interval Between Onset and Death<br>weeks  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Congestive heart Failure<br>Dementia  |  |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>James Sides  |   | 29c. License number<br>D31376  |  | 29d. Date signed (Month, Day, Year)<br>4-10-97                                       |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>James Sides 920 Market St Denton MD   |  |   |   |  |  |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br>APR 14 1997  |  | 32. Registrar's Signature<br>Davidson-Randall   |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12828

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BALFORD THOMAS SHROUT JR.

2. Date of Death

APRIL

Day

8

Year

1997

3. Time of Death

18:40

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

234-42-9355

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 30, 1929

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Rt. 2, Box 142-D

10f. Zip Code

26726

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1953-1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lineman

16b. Kind of Business/Industry

Electric Power Co.

17. Father's Name (First, Middle, Last)

Balford Thomas ShROUT Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lelia Alberta Grapes

19a. Informant's Name/Relationship (Type, Print)

Betty L. ShROUT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 2, Box 142-D Keyser, WV 26726

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ebenezer Cemetery

Date

Apr. 11, 1997

20c. Location - City or Town, State

Romney, WV

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Shaffer Funeral Home, Inc.  
230 East Main St., Romney, WV 26757

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CARDIOGENIC SHOCK

Due to (or as a consequence of):

f. PRIMARY CARDIAL ARRHYTHMIA (SUDDEN DEATH SYNDROME)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

FOURTEEN HOURS

FIFTEEN HOURS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY FIBROSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P33417 (MD)

29d. Date signed (Month, Day, Year)

APRIL 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES R. MOLEN, M.D. 1068 NATIONAL HIGHWAY LAVALE, MARYLAND 21502

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12829

## Certificate of Death

Reg. No.

|   |   |   |  |   |  |  |  |  |   |                                   |
|---|---|---|--|---|--|--|--|--|---|-----------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>RAYMOND ROLAND STEELE</b>                                |   |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 12 1997</b> |  |  |  | 3. Time of Death<br><b>2:10 P.M.</b>                        |                                   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>FROSTBURG VILLAGE NURSING HOME</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>FROSTBURG</b>   |  |  |  | 4c. County of Death<br><b>ALLEGANY</b>                      |                                   |
| Funeral<br>Director   | 5. Social Security Number<br><b>217 10 6293</b>   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 1 1919</b> |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |                                   |
|   | Usual Residence of Decedent<br>10a. State<br><b>MARYLAND</b>  |   |  |   | 10b. County<br><b>ALLEGANY</b>                             |  |  |  | 10c. City, Town or Location<br><b>FROSTBURG</b>             |                                   |
| To Be Completed by Funeral Director   |   | 10e. Street and Number<br><b>100 HONEYSUCKLE LANE</b>   |  |   |  | 10f. Zip Code<br><b>21532</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b>   |   |                                   |
|   |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |   |                                   |
|   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>LABORER</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>BRICKYARD</b>                                   |   |                                   |
|   |   | 17. Father's Name (First, Middle, Last)<br><b>FRANCIS KIRBY</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE STEELE</b>   |  |  |   |                                   |
|   |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>DENNIS A. STEELE/SON</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RR2, BOX 256-1B, MILLVILLE, PA 17846</b>   |  |  |   |                                   |
|   |   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FROSTBURG MEMORIAL PARK 4/15/97</b>  |  | Date<br><b>4/15/97</b>   |  | 20c. Location - City or Town, State<br><b>FROSTBURG, MD 21532</b>                    |   |                                   |
|   |   | 21. Signature of Funeral Service Licensee<br><i>Marilee M. Sowers</i>   |  |   |  | 22. Name and Address of Facility<br><b>SOWERS FUNERAL HOME, P.A.<br/>60 W. MAIN ST., FROSTBURG, MD 21532</b>   |  |  |   |                                   |
|   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Large Cell Lymphoma</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>3 1/2 months</b>  |  |  |   |                                   |
| Physician<br>/Medical<br>Examiner   |   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE Lung Disease</b><br><b>Old Cerebral Infarct with Right Hemiplegia</b><br><b>CORONARY ARTERY DISEASE</b>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |                                   |
|   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |                                   |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate. |   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |                                   |
|   |   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how Injury occurred |
| State Registrar   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |                                   |
|   |   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>S. Chang</i>  |  | 29c. License number<br><b>D25638</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 14, 1997</b>                         |   |                                   |
|   |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SATURNINA CHANG M.D. Rt 36 - Frostburg Plaza FROSTBURG, Maryland 21532</b>   |  |   |  |  |  |  |   |                                   |
|   |   | 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>   |  | 32. Registrar's Signature<br><i>John A. Russell</i>   |  |  |  |  |   |                                   |





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State of Maryland / Department of Health and Mental Hygiene

97 12830

## Certificate of Death

Reg. No.

|   |  |   |   |                                       |  |   |  |   |  |
|---|--|---|---|---------------------------------------|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Paul Edward Skelley</b>   |   |   |                                       | 2. Date of Death<br>Month <b>April</b> Day <b>14</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>8:30PM</b>  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b>   |   |   |                                       | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |   | 4c. County of Death<br><b>Allegany</b>   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-92-9062</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                       | 7. Age (In yrs. last birthday)<br><b>22</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Dec 16, 1974</b>                                     |   |  |
|   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Allegany</b>  |                                       | 10c. City, Town or Location<br><b>Cresaptown</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>12708 Meadow Avenue SW</b>  |   |   |                                       | 10f. Zip Code<br><b>21502</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Employee</b>                      |                                       | 16b. Kind of Business/Industry<br><b>Ironworkers Local 568</b>   |   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Edward Skelley</b>   |   |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Deborah (Hedrick)</b>  |   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ed &amp; Deborah Skelley-parents</b>  |   |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12708 Meadow Avenue SW; Cresaptown, MD 21502</b>   |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Restlawn Memorial Gardens</b>  |                                       | Date<br><b>04/17</b>   |   | 20c. Location - City or Town, State<br><b>LaVale, MD</b>                                       |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |                                       | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>   |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Extensive head and neck trauma</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |                                       |  |   |  | Approximate interval Between Onset and Death<br><b>5 days</b>   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |                                       |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown              |  |
|   | 24a. Was an autopsy performed?<br><b>organ donor</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |                                       |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                       |  |   |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>4/9/97</b>   |   | 28b. Time of Injury<br><b>11:07PM</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>passanger thrown from auto when auto hit fixed object</b><br>28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Pinto Rd Pinto Md</b> |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |                                       |  |   |  |   |  |
| 29b. Signature and title of certifier<br> <b>Dpty Med Ex</b>   |  |   |   | 29c. License number<br><b>D 09157</b> |  | 29d. Date signed (Month, Day, Year)<br><b>April 14 1997</b>                                 |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Paul Snow; 124 W. Third Street; Cumberland, MD 21502</b>   |  |   |   |                                       |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>   |  |   |   |                                       |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





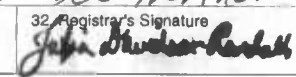
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State of Maryland / Department of Health and Mental Hygiene

97 12831

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |  |   |
|---|---|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES BEVERLY STOCKSLAGER</b>  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 15 1997</b>   |  | 3. Time of Death<br><b>2:50 PM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>18439 WOODSIDE DRIVE</b>   |   |  |  | 4b. City, Town, or Location of Death<br><b>HAGERSTOWN</b>  |  | 4c. County of Death<br><b>WASHINGTON</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-16-0921</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 26, 1920</b>                                    |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>   | 10b. County<br><b>WASHINGTON</b>  | 10c. City, Town or Location<br><b>HAGERSTOWN</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
|   | 10e. Street and Number<br><b>18439 WOODSIDE DRIVE</b>   |   |  | 10f. Zip Code<br><b>21740</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1942-</b><br>If Yes, Give Year or Dates: <b>1946</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed).<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>1 yr.</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>EMPLOYEE TRAINING OFFICER</b>                              |  | 16b. Kind of Business/Industry<br><b>STATE CORRECTIONAL INST.</b>  |  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>HENRY PAUL STOCKSLAGER</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY MARGARET MONGAN</b>   |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>ORPHA M. STOCKSLAGER/SPOUSE</b>  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18439 WOODSIDE DRIVE, HAGERSTOWN, MARYLAND 21740</b> |  |  |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MTN. VIEW CEMETERY</b>  |  | Date<br><b>4/18/97</b>   |  | 20c. Location - City or Town, State<br><b>SHARPSBURG, MARYLAND</b>   |   |
|   | 21. Signature of Funeral Service Licensee<br> <b>Paul M. Dean</b>   |   | 22. Name and Address of Facility<br><b>BAST FUNERAL HOME</b><br><b>7606 Old National Pike</b><br><b>Boonsboro, Maryland 21713</b>  |  |  |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. <u>ATHEROSCLEROTIC CORONARY ARTERY DISEASE</u></b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. _____</b><br>Due to (or as a consequence of):<br><b>c. _____</b><br>Due to (or as a consequence of):<br><b>d. _____</b> |   |  |  |  |  |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b><u>nephroses</u></b>   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how injury occurred                           |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br> <b>J. N. Weeks</b>   |  |  |  |  |  |   |
| 29c. License number<br><b>011266</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 16 97</b>   |  |  |  |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>H. M. Weeks 680 Northorn Av Hagerstown, Md</b>   |   |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 17 1997</b>   |   | 32. Registrar's Signature<br>  |  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Registrar

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State of Maryland / Department of Health and Mental Hygiene

97 12832

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY JEAN SHUPP

2. Date of Death

April 13, 1997

3. Time of Death

18:40

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

214-34-2471

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 17, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Williamsport

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14724 Clear Spring Road

10f. Zip Code

21795

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Shipping Clerk

16b. Kind of Business/Industry

Ribbon Manf.

17. Father's Name (First, Middle, Last)

Ivan McAllister Holland

18. Mother's Name (First, Middle, Maiden Surname)

Susie NMI Leigh

19a. Informant's Name/Relationship (Type, Print)

Donald Lee Shupp/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14724 Clear Spring Rd. Williamsport, MD 21795

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rose Hill Cemetery

Date

4-16-97

20c. Location - City or Town, State

Clear Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home 425 S. Conococheague St.  
Williamsport, MD 2179523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. MYOCARDIAL INFARCTION, ACUTE, SUSPECTED

Due to (or as a consequence of):

SUDDEN

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D01040

29d. Date signed (Month, Day, Year)

04-14-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARRY M. COMBS MD, 18206 CAESTWOOD DR, HAGERSTOWN, MD, 21742

31. Date filed (Month, Day, Year)

APR 15 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

97 12833

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ellen D Sharpley</b>   |  | 2. Date of Death<br>Month <b>April</b> Day <b>12</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>0907</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>   |  | 4c. County of Death<br><b>WICOMICO</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-05-9101</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>07-12-10</b> | 9. Birthplace (State or Foreign Country)<br><b>Stockton, MD</b>  |
|   | Usual Residence of Decedent   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>VA</b>   | 10b. County<br><b>Accomack</b>   | 10c. City, Town or Location<br><b>Greenbackville</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>Church Street</b>  |  | 10f. Zip Code<br><b>23356</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/> |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Campbells Soup Employee</b>   |  | 16b. Kind of Business/Industry<br><b>factory</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Capt. Benjamin Disharoon</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eva D.</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eldon Sharpley/Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Smithfield, VA</b>   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenbackville Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>4-14-97 Greenbackville, VA</b>   |
|   | 21. Signature of Funeral Service Licensee<br><b>James H. Fox</b>  |  | 22. Name and Address of Facility<br><b>Fox Funeral Homes<br/>P. O. Box 278-Temperanceville, VA 23442</b>   |  |  |
|   | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Respiratory Arrest</b><br>Due to (or as a consequence of):<br>b. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br>c. <b>Acute Renal Failure</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Unsepsis</b> <b>Digoxin toxicity</b><br><b>Aspiration pneumonia</b>  |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   |  |  |  |  |
| 28a. Date of Injury (Month, Day Year)<br><b>28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b>  |   |  |  |  |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |  |  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |  |  |
| 28d. Describe how Injury occurred   |   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |  |
| 29b. Signature and title of certifier<br><b>James H. Fox MD</b>   |   |  |  |  |  |
| 29c. License number<br><b>D0050614</b>  |   |  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>4/14/97</b>   |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>262 Tilghman Rd Salisbury MD 21804</b>   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>   |   |  |  |  |  |
| 32. Registrar's Signature<br><b>John A. ...</b>   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12834

## Certificate of Death

Reg. No.

|  |   |   |   |                                  |  |  |  |  |  |
|--|---|---|---|----------------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Bernice Woods Jenkins Smith   |   |   |                                  | 2. Date of Death<br>Month: March, Day: 25, Year: 1997  |  | 3. Time of Death<br>21:17 hrs.   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Saint Agnes Hospital  |   |   |                                  | 4b. City, Town, or Location of Death<br>Baltimore City   |  | 4c. County of Death<br>n/a   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>246-30-0482  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>77 Yrs.   | If Under 1 Year<br>Months: Days: | If Under 24 Hrs.<br>Hours: Min:  | 8. Date of Birth (Month, Day, Year)<br>June 17, 1919   |  | 9. Birthplace (State or Foreign Country)<br>North Carolina |  |
|  | Usual Residence of Decedent   |   |   |                                  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  |   | 10b. County<br>Howard   |                                  | 10c. City, Town or Location<br>Elkridge  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br>6380 Meadowridge Road   |   |   |                                  | 10f. Zip Code<br>21227   |  | 10g. Citizen of What Country?<br>United States   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12th grade<br>College (1-4 or 5+):  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Elevator Operator                        |                                  | 16b. Kind of Business/Industry<br>D.C. Government/<br>Dept. General Services   |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>unknown  |   |   |                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br>unknown   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Paula Williams Hamm (God-daughter)  |   |   |                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1136 Windmill Lane, Silver Spring, Maryland 20905   |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Glenwood Cemetery/March 31, 1997  |                                  | 20c. Location - City or Town, State<br>Washington, D.C.  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br>Latney's Funeral Home, Inc.<br>3831 Georgia Avenue, N.W.; Washington, D.C. 20011                                  |                                  |  |  |  |  |  |
|  | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |   |   |                                  |  |  |  |  |  |
|  | Immediate Cause (Final disease or condition resulting in death)   |   | Myocardial Infarction   |                                  |  |  | Approximate Interval Between Onset and Death<br>Immediate  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   |   | Due to (or as a consequence of):  |   |                                  |  | 5 years  |  |  |  |
|  |   | Diabetes Mellitus   |   |                                  |  |  |  |  |  |
|  |   | Due to (or as a consequence of):  |   |                                  |  |  |  |  |  |
|  |   | Due to (or as a consequence of):  |   |                                  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |                                  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |   |   |   |                                  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  |   |   |   |                                  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                          |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |                                  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |   |   |   | 29c. License number<br>D04345    |  | 29d. Date signed (Month, Day, Year)<br>April 3, 1997<br>March 27, 1997   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Columbia Medical Plan Building No: 2;<br>Marguerite Summers, M.D.; 2 Knoll North Drive; Columbia, Maryland 21045   |   |   |   |                                  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 10 1997   |   | 32. Registrar's Signature<br>   |   |                                  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 12835

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Queen SANDERS

2. Date of Death

Month Day Year  
April 4, 1997

3. Time of Death

10:20PM

4e. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-24-3234

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

03 05 1913

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Seat Pleasant

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6313 Seat Pleasant Drive

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6th

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Domestic Worker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Hilliard Cooper

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Arrington

19a. Informant's Name/Relationship (Type, Print)

Geraldine Simmons/Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8712 Temple Hill Road, Clinton, Maryland 20735

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

04/11  
1997

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perenthi

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. CARDIAC ARREST

MINUTES

Due to (or as a consequence of):

b. MASSIVE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SERVING ATHEROSCLEROSIS

ISCHEMIA OF LEGS

RENOVASCLULAR HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31069

29d. Date signed (Month, Day, Year)

APRIL 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE BONE, MD

9602F

M.L. KING, JR. HIGHWAY, LANHAM, MD 20706

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12836

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Silas Shambly

2. Date of Death

Month Day Year  
APRIL 1, 1997

3. Time of Death

12:49PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3923 23rd Parkway Apt 2

4b. City, Town, or Location of Death

Temple Hills

4c. County of Death

Prince Georges

5. Social Security Number

243-20-4787

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
MARCH 31, 1926

9. Birthplace (State or Foreign Country)

POWELLSVILLE, N.C.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

TEMPLE HILLS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3923 23RD PARKWAY

10f. Zip Code

20748

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11TH

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPPLY TECH

16b. Kind of Business/Industry

MILITARY

17. Father's Name (First, Middle, Last)

SILAS SHAMBLBY, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MAGGIE HARDY

19e. Informant's Name/Relationship (Type, Print)

ELLA OPHELIA SHAMBLBY/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1004 SOUTHLAKE COVE CT. JONESBORO, GA. 30236

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON NATIONAL

Date

4/7/97

20c. Location - City or Town, State

ARLINGTON, VIRGINIA

21. Signature of Funeral Service Licensee

Kerthle Savage

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other:

4 ☒ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. C. Clark, M.D.

29c. License number

Acting Med Examiner  
205735

29d. Date signed (Month, Day, Year)

4/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. C. Clark, M.D., 3001 Hospital Dr. Chevy Chase, Md. 20785

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

John Anderson Randall

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6 1/5

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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State of Maryland / Department of Health and Mental Hygiene

97 12837

## Certificate of Death

Reg. No.

Amended # 31. P.G.C. 4-7-97 CR

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Reba

Shoulders

2. Date of Death

Month

Day

Year

March 31, 1997

3. Time of Death

6:30 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Presidential Woods Nursing Home

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

5. Social Security Number

218-64-0887

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 12, 1920

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bladensburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5999 Emerson Street, Apt. #723

10f. Zip Code

20710

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

David Johnson

18. Mother's Name (First, Middle, Maiden Summa)

Eddie Washington

19a. Informant's Name/Relationship (Type, Print)

Johnnie Shoulders, Sr.-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5999 Emerson Street Apt. 723, Bladensburg, MD 20710

20a. Method of Disposition

1 ☒ Burial2 ☐ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD National Memorial Park 4/7/97

Date

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Claudette S. Gasch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, Md 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypotension

Due to (or as a consequence of):

b. Urosepsis

Due to (or as a consequence of):

c. Cerebrovascular Accident

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizures

Rt hemicolectomy

Chronic Diarrhea

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Nayak

29c. License number

347259

29d. Date signed (Month, Day, Year)

April 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nayak, M.D.

6501 Landover Road, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

4/2/97

32. Registrar's Signature

APR 07 1997

Julia Steward-Rodall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

3





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12838

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Agnes Stansbury

2. Date of Death  
Month  
AprilDay  
6Year  
19973. Time of Death  
3:20 AM

4a. Facility Name (If not institution, give street and number)

Heartland Health Care Center

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-01-9244

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

May 18, 1907

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4921 56th Avenue

10f. Zip Code

20781

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Meiers

18. Mother's Name (First, Middle, Maiden Surname)

Celestie Palmer

19a. Informant's Name/Relationship (Type, Print)

Evelyn Taylor - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2006 Valley View Dr., Fort Washington, Maryland 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

04/08/97

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

W. B. Gerson

22. Name and Address of Facility

Francis Gasch's Sons Funeral

Home, 4739 Baltimore Avenue, Hyattsville, Md. 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Aunt Myelogenous Leukemia

Approximate Interval Between Onset and Death

2 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. B. Gerson

29c. License number

D25079

29d. Date signed (Month, Day, Year)

4-7-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DON A. YADLOVSKY, MD 7404 Executive place #222 Bethesda, MD 20706

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12839

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Frances Hines Scherl   |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br>April 9, 1997   |  | 3. Time of Death<br>9:12 am  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Prince George's Hospital Center  |  |   |  |   |  | 4b. City, Town, or Location of Death<br>Cheverly  |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director  | 5. Social Security Number<br>278-10-9696   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>80 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>June 9, 1916   |  | 9. Birthplace (State or Foreign Country)<br>Ohio   |  |
|  | Usual Residence of Decedent  |  |   |  |   |  |   |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD   |  | 10b. County<br>Prince George's  |  | 10c. City, Town or Location<br>Cheverly   |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br>2305 Cheverly Avenue   |  |   |  | 10f. Zip Code<br>20785  |  | 10g. Citizen of What Country?<br>U.S.A.   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  |   |  | 16b. Kind of Business/Industry<br>Own Home  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Thomas Hines  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Helen Hodge  |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br>Francis Butterworth - Daughter   |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1695 Brickhouse Bar Court, Annapolis, Maryland 21401 |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery   |  | 20c. Date<br>04/12/97   |  | 20d. Location - City or Town, State<br>Silver Spring, MD  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Loni Lynn Gasch-Meady   |  |   |  |   |  | 22. Name and Address of Facility<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Avenue, Hyattsville, MD 20781                           |  |  |  |
|  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ARTERIOSCLEROTIC HEART DISEASE<br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |   |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Dementia - multi-infarct type<br>CHRONIC OBSTRUCTIVE LUNG DISEASE  |  |   |  |   |  |   |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>Ira N. Tublin M.D.   |  | 29c. License number<br>D11485   |  | 29d. Date signed (Month, Day, Year)<br>April 10, 1997   |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Ira N. Tublin, M.D. 8830 Cameron Street, Silver Spring, Maryland 20910-4114  |  |   |  |   |  |   |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br>APR 11 1997   |  | 32. Registrar's Signature<br>John A. Russell  |  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12840

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |   |  |
|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Emma Frances Shoemaker</b>  |  | 2. Date of Death<br>Month <b>April</b> Day <b>04</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>2140</b>  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>  |   | 4c. County of Death<br><b>MONTGOMERY</b>   |
| 5. Social Security Number<br><b>213-44-5509</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>87</b>   | 8. Date of Birth (Month, Day, Year)<br><b>Mar 7, 1910</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
| Usual Residence of Decedent  |  |   |   |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Rockville</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>403 Broadwood Drive</b>   |  | 10f. Zip Code<br><b>20851</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edward Shipley</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Cheesman</b>  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Carol Jean Shoemaker, Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>403 Broadwood Drive, Rockville, MD 20851</b>  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Dr., Gaithersburg, MD 20877</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |  |
| Immediate Cause (Final disease or condition resulting in death)  |  | e. <b>CARDIOGENIC SHOCK</b><br>Due to (or as a consequence of):   |   | Approximate Interval Between Onset and Death<br><b>1 DAY</b>   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | b. <b>ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):   |   | <b>1 DAY</b>   |
|  |  | c. <b>ACUTE RENAL FAILURE</b><br>Due to (or as a consequence of):   |   | <b>1 DAY</b>   |
|  |  | d.  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |
| 29b. Signature and title of certifier<br><b>D. Vikramaditya Reddy MD</b>   |  | 29c. License number<br><b>D43464</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 05 1997</b>  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>VIKRAMADITYA D. REDDY, 1125 ROCKVILLE PIKE, SUITE #303, ROCKVILLE, MD - 20852</b>   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1997</b>  |  | 32. Registrar's Signature<br>   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

5

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12841

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys Shulman

2. Date of Death

Month Day Year  
April 6, 1997

3. Time of Death

11:52 PM

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-48-9908

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 4, 1904

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6121 Montrose Road

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Grocery Business

17. Father's Name (First, Middle, Last)

Jacob Pollack

18. Mother's Name (First, Middle, Maiden Surname)

Clara Broadlieb

19a. Informant's Name/Relationship (Type, Print)

J. Stephen Turett Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4415 Langtry Drive, Glen Arm, Maryland 21057

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Vista Memorial Gardens

Date

4-15-97

20c. Location - City or Town, State

Hialeah, Florida

21. Signature of Funeral Service Licensee

Ellen H. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

P. Talwar, MD

29c. License number

D36552

29d. Date signed (Month, Day, Year)

April 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Pankaj Talwar, M.D. 6121 Montrose Road, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12842

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

SHIRLEY ANN SIMMONS

2. Date of Death

Month Day Year  
APRIL 02 1997

3. Time of Death

10:40 PM

4a. Facility Name (If not institution, give street and number)

National Institute of Health

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

214-36-3549

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 17, 1939

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4312 Independence Street

10f. Zip Code

20853-3829

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

School Cafeteria Service

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Kermit Smith Fones

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Dare Reynolds

19a. Informant's Name/Relationship (Type, Print)

Mr. Stanley W. Simmons

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4312 Independence Street, Rockville, MD 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

4/5/1997

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

J. Kerin Gutowski

22. Name and Address of Facility

Francis Collins Funeral Home, Inc  
500 University Blvd. W., S.Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Follicular Lymphoma  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

5 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and Title of Certifier

J. Kerin Gutowski, Fellow

29c. License number

VA0108037096

29d. Date signed (Month, Day, Year)

4/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rd 10 Room 12N 226 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

State  
Registrar

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

John Davidson-Rodell

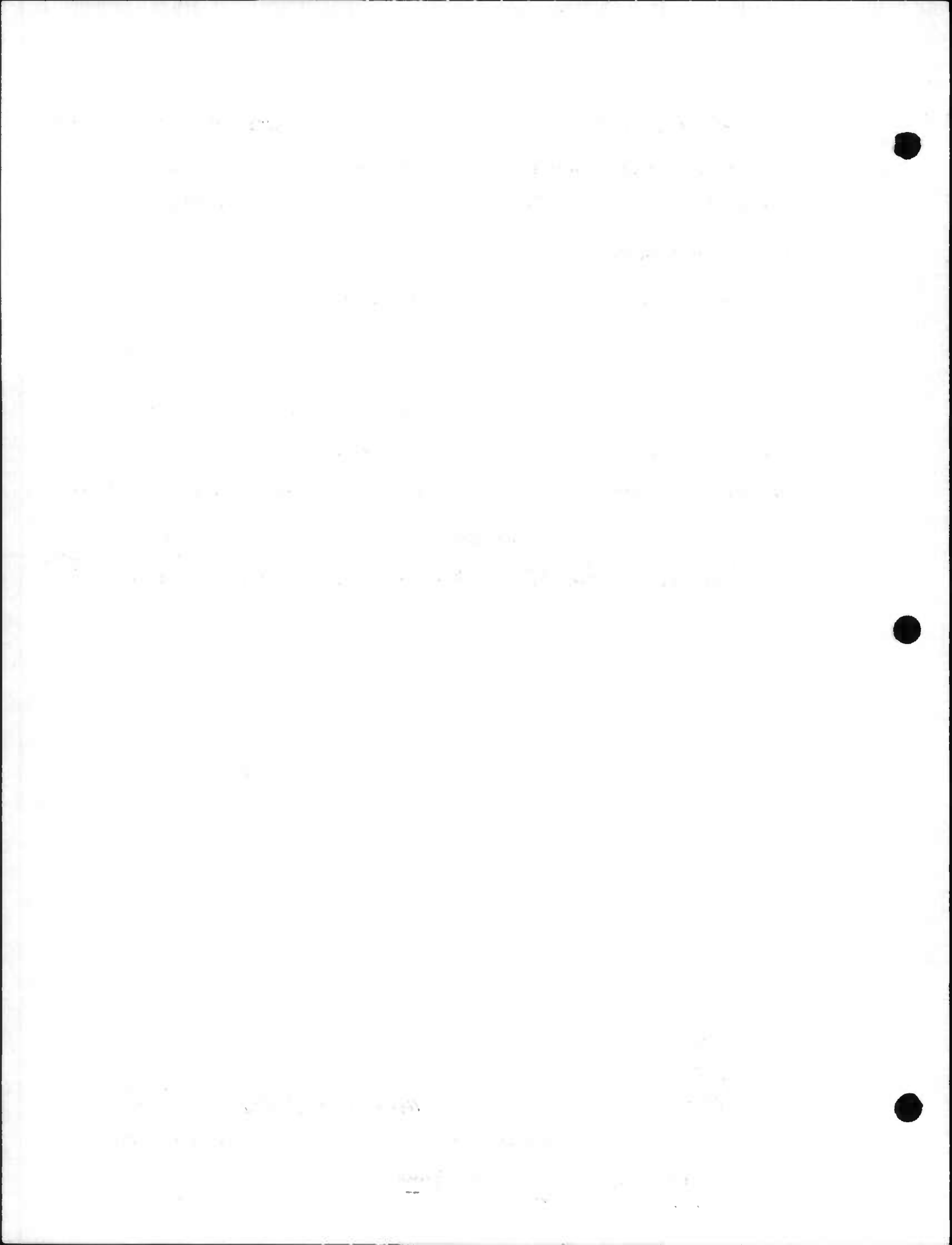
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12843

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Selwyn Salzberg

2. Date of Death  
Month Day Year  
Apr 7 1997

3. Time of Death  
11<sup>10</sup> AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number  
015-05-8821

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)  
77 Yrs.

If Under 1 Year  
Months Days  
If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)  
Mar. 14, 1920

9. Birthplace (State or Foreign  
Country)  
MA

Usual Residence of Decedent

10e. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10207 Duvawn Place

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1942-  
1959

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Sales Manager

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Max Salzberg

18. Mother's Name (First, Middle, Maiden Surname)

Annie Goldberg

19a. Informant's Name/Relationship (Type, Print)

Mrs. Edith F. Salzberg

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10207 Duvawn Place, Silver Spring, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Veteran

Date

4/10/97

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

William L Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home  
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Respiratory Failure

Approximate  
Interval Between  
Onset and Death

1 day

b. Due to (or as a consequence of):

Sepsis

3 days

c. Due to (or as a consequence of):

Myelodysplastic Syndrome

6 mo.

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thrombocytopenia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury  
(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29e. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Peter B. Sherer MD

29c. License number

D21910

29d. Date signed (Month, Day, Year)

April 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter B. Sherer MD 3947 Ferrara Dr Wheaton, MD 20906

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10 + 1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12844

## Certificate of Death

Reg. No.

|   |   |  |  |   |  |  |   |   |
|---|---|--|--|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Eugene Spears</b>  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>April 2, 1997</b>   |  | 3. Time of Death<br><b>6:00 AM</b>                                      |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Circle Manor Nursing Home</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>Kensington</b>  |  | 4c. County of Death<br><b>Montgomery</b>                                |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>555-03-7918</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 24, 1916</b>                                    |   | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b> |
|   | Usual Residence of Decedent   |  |  |   |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Kensington</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |
|   | 10e. Street and Number<br><b>10231 Carroll Place</b>  |  |  | 10f. Zip Code<br><b>20895</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MASTER SERGEANT</b>                            |   |  | 16b. Kind of Business/Industry<br><b>ARMY</b>  |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Henry Spears</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gladys Evelyn Frew</b>   |  |   |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ann S. Lawson</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1002 North Pelham Street Alexandria, Virginia 22304</b>                                  |  |   |   |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |   | Date<br><b>4/04/97</b>   | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>                             |   |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Steven D. Stindel</i>   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W., Silver Spring, MD 20901</b>                         |   |  |  |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cerebrovascular accidents</b><br>Due to (or as a consequence of):<br><br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |  |   |   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |   |  |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)                                     |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how Injury occurred                           |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |   |  |  |   |   |
| 29b. Signature and title of certifier<br><i>Jeannette P. Asher</i>  |   |  |  | 29c. License number<br><b>D34032</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/3/97</b>   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JEANETTE P. ASHER 3720 FARRAGUT AVE KENSINGTON MD 20895</b>  |   |  |  |   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1997</b>   |   |  |  | 32. Registrar's Signature<br><i>Davidson-Randall</i>  |  |  |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5 + 1

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12845

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nizar

Aref

Sleem

2. Date of Death

March

Day

31

Year

1997

3. Time of Death

5:20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

10 C Southway Road

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince Georges

5. Social Security Number

218 94 4981

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb. 1, 1934

9. Birthplace (State or Foreign Country)

Jordan

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Maryland Prince Georges Greenbelt

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10 C Southway Road

10f. Zip Code

20770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Guard

16b. Kind of Business/Industry

Security

17. Father's Name (First, Middle, Last)

Aref Yousef Sleem

18. Mother's Name (First, Middle, Maiden Surname)

Kuthar Zaim

19a. Informant's Name/Relationship (Type, Print)

Ziad Sleem/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1522 Thurber St., Herndon, VA. 20170

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

National Memorial Pk

Date

4/3/97

20c. Location - City or Town, State

Falls Church, VA.

21. Signature of Funeral Service Licensee

Mark Jensen

22. Name and Address of Facility

Everly-Colonial Funeral Home

6161 Leesburg Pk, Falls Church, VA. 22044

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Prostate Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

8 years

b.

lung cancer

Due to (or as a consequence of):

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

severe coronary artery disease

Due to (or as a consequence of):

18 months

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Chitra Venkatraman

29c. License number

041715

29d. Date signed (Month, Day, Year)

4.1.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Chitra Venkatraman 7343A Hanover Parkway, Greenbelt, Maryland

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12846

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen J. Sawyer

2. Date of Death

Month Day Year  
March 21, 1997

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

2703 Loma Street

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

125-10-9612

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 6, 1919

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2703 Loma Street

10f. Zip Code

20902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Bernard Helkowski

18. Mother's Name (First, Middle, Maiden Surname)

Stella Cuk

19a. Informant's Name/Relationship (Type, Print)

Peter F. Sawyer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2703 Loma Street Silver Spring, Maryland 20902

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

3/25/97 Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Kevin Gutowski

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Boulevard, W., Sil. Spr., MD 2090123a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiovascular Collapse

Due to (or as a consequence of):

b. Cardiac Arrhythmias

Due to (or as a consequence of):

c. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

5 years

10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Shy-Drager Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Joseph M. Solinas

29c. License number

D10101

29d. Date signed (Month, Day, Year)

3/22/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joseph M. Solinas, M.D. 9801 Georgia Avenue Silver Spring, Maryland 20902-5276

31. Date filed (Month, Day, Year)

MAR 25 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12847

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MINNIE SKIBINSKY SELFON

2. Date of Death

Month Day Year  
APRIL 03 1997

3. Time of Death

8:25pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Genesis Elder Care

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

165-14-5995

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 4, 1910

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

13116 Foxhall Drive

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Jacob Skibinsky

18. Mother's Name (First, Middle, Maiden Surname)

Eva Boyer

19a. Informant's Name/Relationship (Type, Print)

Dr. Paul Selfon (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13116 Foxhall Drive Silver Spring, MD 20906

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Judean Memorial Gardens 4/6/97

Date

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Danzansky-Goldberg Memorial Chapels, Inc.  
1170 Rockville Pike, Rockville, MD. 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 week

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Adenoid cystic carcinoma of Left submandible

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying PhysicianTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Wilkinson J. Ninala

29c. License number

D 45285

29d. Date signed (Month, Day, Year)

April 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wilkinson J. Ninala 18111 Prince Philip Dr, #212 Olney, MD 20832

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

Julia Davidson-Rendall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion and summary of the work.

5. The fifth part is a list of references.

6. The sixth part is a list of figures.

7. The seventh part is a list of tables.

8. The eighth part is a list of appendices.

9. The ninth part is a list of footnotes.

10. The tenth part is a list of symbols.

11. The eleventh part is a list of abbreviations.

12. The twelfth part is a list of acronyms.

13. The thirteenth part is a list of definitions.

14. The fourteenth part is a list of terms.

15. The fifteenth part is a list of phrases.

16. The sixteenth part is a list of sentences.

17. The seventeenth part is a list of paragraphs.

18. The eighteenth part is a list of sections.

19. The nineteenth part is a list of chapters.

20. The twentieth part is a list of volumes.

21. The twenty-first part is a list of issues.

22. The twenty-second part is a list of parts.

23. The twenty-third part is a list of sections.

24. The twenty-fourth part is a list of chapters.

25. The twenty-fifth part is a list of volumes.

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State of Maryland / Department of Health and Mental Hygiene

97 12848

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |   |  |   |  |
|---|--|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Victoria Sophia Schaffer</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>April 7, 1997</b>   |   | 3. Time of Death<br><b>6:24PM</b>  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>209 Northwest Terrace</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |   | 4c. County of Death<br><b>Montgomery</b>   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>323-07-6473</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 18, 1905</b>  | 9. Birthplace (State or Foreign Country)<br><b>Poland</b> |  |
|   | Usual Residence of Decedent  |   |   |  |  |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
|   | 10e. Street and Number<br><b>209 Northwest Terrace</b>   |   |   |  | 10f. Zip Code<br><b>20901</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Executive Secretary</b>           |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Stephen Korus</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Barnas</b>  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Edward E. Schaffer</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20901</b><br><b>209 Northwest Terrace Silver Spring, Maryland</b>                           |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Sepulchre Cemetery</b>  |  | Date<br><b>4/12/97</b>   |   | 20c. Location - City or Town, State<br><b>Worth, Illinois</b>  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.</b><br><b>500 University Blvd., W., Silver Spring, MD 20901</b>   |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Cerebral Infarctions</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred                         |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D 08944</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>April 8, 1997</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Martin C. Shargel, M.D. 3720 Farragut Avenue Kensington, Maryland 20895-2110</b>   |  |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 10 1997</b>   |  | 32. Registrar's Signature<br>  |   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12849

## Certificate of Death

Reg. No.

|   |  |  |  |   |   |  |  |   |   |  |  |
|---|--|--|--|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Laura J. Sisson</b>                           |  |  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>April 5, 1997</b>   |   | 3. Time of Death<br><b>12:58 PM</b>                             |  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b> |  |  |   |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>                                       |   | 4c. County of Death<br><b>Montgomery</b>                        |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>208-18-1322</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.    |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 16, 1925</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |  |  |
|   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>   |   | 10c. City, Town or Location<br><b>Silver Spring</b> |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |   |  |  |
| 10e. Street and Number<br><b>1906 Alberti Drive</b>   |  | 10f. Zip Code<br><b>20902</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Licensed Practical Nurse</b> |  | 16b. Kind of Business/Industry<br><b>Health Care</b>  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Don Walter Lewis</b>  |  |  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Margaret Matthews</b>   |  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda L. Sisson</b>  |  |  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1906 Alberti Drive Silver Spring, Maryland 20902</b>                               |  |   |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b> |   | Date<br><b>4/05/97</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Eric S. Sisson</i>  |  |  |  |   |   | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W. Silver Spring, MD 20901</b>  |  |   |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><br>b. <b>Pneumonia</b><br>Due to (or as a consequence of):<br><br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Approximate Interval Between Onset and Death<br><br><b>3 Years</b><br><br><b>1 Day</b> |  |  |  |   |   |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Diabetes</b>   |  |  |  |   |   |  |  |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |   |   |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |   |   |  |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |   |   |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |   |   |  |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |   |   |  |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br><i>Shomekhan</i> <b>PHYSICIAN</b>                              |   | 29c. License number<br><b>D 40804</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>04/05/1997</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Kewal K. Sharma, M.D. 10620 Georgia Avenue Silver Spring, Maryland 20902</b>   |  |  |  |   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 10 1997</b>   |  |  |  |   |   |  |  |   |   |  |  |
| 32. Registrar's Signature<br><i>Davidson-Randall</i>  |  |  |  |   |   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12850

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LISA KAREN STEINBERG

2. Date of Death

Month Day Year  
APRIL 5, 1997

3. Time of Death

6:53pm

4a. Facility Name (If not institution, give street and number)

11004 SUGARBUSH TERRACE

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

219 48 0316

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JAN. 31, 1956

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11004 SUGARBUSH TERRACE

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
WHITE15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

PHYSICIAN

16b. Kind of Business/Industry

PODIATRY

17. Father's Name (First, Middle, Last)

SAMUEL STEINBERG

18. Mother's Name (First, Middle, Maiden Surname)

JANET SCHLEIN

19a. Informant's Name/Relationship (Type, Print)

MITCHELL MELLEN/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11004 SUGARBUSH TERRACE ROCKVILLE, MD. 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

KING DAVID MEM. GDNS.

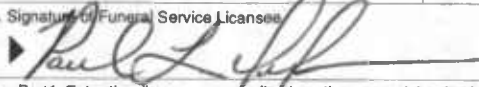
Date

4/8/97

20c. Location - City or Town, State

FALLS CHURCH, VA.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

IVES-PEARSON FUNERAL HOMES

472 N. WASHINGTON ST. FALLS CHURCH, VA. 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. *Metastatic Breast Cancer*

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 years.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier



29c. License number

D33293-Md.

29d. Date signed (Month, Day, Year)

APRIL 9, 1997

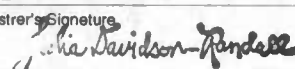
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRED SMITH, MD 5401 WESTERN AVENUE WASHINGTON, D.C. 20015

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12851

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH ISABELLE STORER

2. Date of Death

Month Day Year  
APRIL 15, 1997

3. Time of Death

0310am

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

214-07-3338

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Sep 27, 1904

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

100 Honeysuckle Lane

10f. Zip Code

21532

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired

16b. Kind of Business/Industry

Textile

17. Father's Name (First, Middle, Last)

Charles D. Hines

18. Mother's Name (First, Middle, Maiden Surname)

Clara (Viets)

19a. Informant's Name/Relationship (Type, Print)

Jane Price--P.R.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Bernard Street; Frostburg, MD 21532

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory

Date

04/15

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Suppurative Diverticulitis  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Gary Wagoner MD

29c. License number

D22181

29d. Date signed (Month, Day, Year)

APRIL 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Gary Wagoner, Bishop Walsh Drive; Cumberland, MD 21502

31. Date filed (Month, Day, Year)

APR 16 1997

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12852

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Tamara

Kathleen

Thompson

2. Date of Death

April

07

1997

3. Time of Death

7:27 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

219-88-8172

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

29 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 9, 1967

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Marys

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

47453 Lincoln Avenue

10f. Zip Code

20653

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
316a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Charles

H.

Thompson

18. Mother's Name (First, Middle, Maiden Surname)

Juanita

Smith

19a. Informant's Name/Relationship (Type, Print)

Juanita Butler/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

47453 Lincoln Ave. Lexington Park, MD 20653

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion UM Chr. Cem.

Date

4/12/97

20c. Location - City or Town, State

St. Inigoes, MD

21. Signature of Funeral Service Licensee

Spencer E. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Rd. Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Cardiomyopathy  
Due to (or as a consequence of):  
Diabetic Mellitus

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael A. Leatherwood, MD

29c. License number

D - 21031

29d. Date signed (Month, Day, Year)

4/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Leatherwood, MD 700 Old Line Center, Suite 202 Waldorf, Maryland 20601

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

L.H. Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1991

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12853

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Noble Taylor

2. Date of Death

Month Day Year  
April 8, 1997

3. Time of Death

11:50pm

4a. Facility Name (If not institution, give street and number)

Memorial Hospital @ Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

218-16-8247

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08/03/22

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2355 Guard Road

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Tri-Gas &amp; Oil Co.

17. Father's Name (First, Middle, Last)

R. Noble Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Flora Williamson Taylor

19a. Informant's Name/Relationship (Type, Print)

Naomi T. Taylor/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2355 Guard Rd., Federalsburg, MD 21632

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Junior Order Cemetery 4-12

Data

20c. Location - City or Town, State

Preston, Maryland

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home  
PO Box 43, Federalsburg, MD 21632

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic heart disease

Due to (or as a consequence of):

4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory failure due to obstructed trachea

Due to (or as a consequence of):

12 days

c. myocardial infarction with end stage renal disease

Due to (or as a consequence of):

1991

d. anemia of chronic disease

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Depression. obstructive sleep apnea  
aspiration of gastric contents.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Syed Ali

29c. License number

D46020

29d. Date signed (Month, Day, Year)

4/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Ali, M.D., 606 Dutchman's Lane, Easton, MD 21601

31. Date filed (Month, Day, Year)

APR 14 1997

32. Registrar's Signature

John Michael Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





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State of Maryland / Department of Health and Mental Hygiene

97 12854

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Mae Tucker

2. Date of Death

April 8, 1997

3. Time of Death

4:10 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

212-38-2385

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 10, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Union Bridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1240 McKinstry Mill Rd.

10f. Zip Code

21791

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
nurse/secretary/instructional  
assistant16b. Kind of Business/Industry  
public  
hospital/school

17. Father's Name (First, Middle, Last)

John Joseph Howard

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Milberry

19a. Informant's Name/Relationship (Type, Print)

George L. Tucker, Sr./ husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21791  
1240 McKinstry Mill Rd., Box 494 Union Bridge, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. James Cemetery

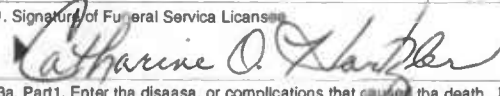
Date

4/12/97

20c. Location - City or Town, State

nr. New Windsor, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hartzler Funeral Home  
Union Bridge, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *hepato renal syndrome*  
Due to (or as a consequence of):

44

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *massive liver metastases*  
Due to (or as a consequence of):

60

c. *colon carcinoma*  
Due to (or as a consequence of):

6 mo

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D14626

29d. Date signed (Month, Day, Year)

APR 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Gregory Rausch

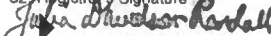
501 W. 7th St.

Frederick, MD

31. Date filed (Month, Day, Year)

APR 14 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12855

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Allen Tosten

2. Date of Death

Month, Day, Year  
April 9, 1997

3. Time of Death

1230 PM

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-64-7011

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 15 1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

W. Va.

10b. County

Berkeley

10c. City, Town or Location

Falling Waters

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 Bowie Drive Apt. 24

10f. Zip Code

25419

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Glenn O. Tosten

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Semler

19a. Informant's Name/Relationship (Type, Print)

Pat Heishman/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Bowie Drive Apt. 24 Falling Waters, W.Va 25419

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

Hagerstown Crematory 4/11/97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Fred L. Tosten

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hodgkin's Disease  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. McCormack MD

29c. License number

041667

29d. Date signed (Month, Day, Year)

4.9.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael J. McCormack 11110 Medical Campus Suite 130 Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

APR 11 1997

32. Registrar's Signature

John P. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12856

|  |  |   |  |  |   |  |   |  |  |
|--|--|---|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ERMA LILLIAN TORRES</b>                             |   |  |  | 2. Date of Death<br>Month: <b>4</b> Day: <b>7</b> Year: <b>97</b> |  | 3. Time of Death<br><b>1510</b>                       |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Atlantic General Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Berlin</b>             |  | 4c. County of Death<br><b>Worcester</b>               |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>221-16-1878</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.                  |  | 8. Date of Birth (Month, Day, Year)<br><b>6/26/26</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>  |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Worcester</b>                                   |  | 10c. City, Town or Location<br><b>Ocean City</b>      |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>11 Philadelphia Ave.</b>  |   | 10f. Zip Code<br><b>21842</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                                  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Hotel Manager</b>   |  | 16b. Kind of Business/Industry<br><b>Tourism</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Chester Archie Lynch</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Olive Mae Hudson</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John Torres / Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1141 Centerville RD Newville, PA 19724</b>  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cape Henlopen Crematory 4/11/97 Frankford, DE</b>                     |   | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>Burbage Funeral Home<br/>108 William St. Berlin, MD 21811</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. sepsis (unknown source)</b><br>Due to (or as a consequence of):<br><b>b. renal failure</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>unknown</b>  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i><br><b>Robert Durkin physician</b>   |  | 29c. License number<br><b>H44283</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/7/97</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert Durkin<br/>9733 Herkimer Drive<br/>Berlin, MD</b>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 09 1997</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i><br><b>Jahia Davidson-Randall</b>   |   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12857

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JANICE ELIZABETH TANNER

2. Date of Death

Month Day Year  
April 8, 1997

3. Time of Death

4:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

10009 Old Franklin Avenue

4b. City, Town, or Location of Death

Seabrook

4c. County of Death

Prince Georges

5. Social Security Number

278-12-3309

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 24, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Prince Georges

10c. City, Town or Location

Seabrook

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

10009 Old Franklin Avenue

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Caucasian

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John F. Hauck

18. Mother's Name (First, Middle, Maiden Surname)

Grace Hutchinson

19a. Informant's Name/Relationship (Type, Print)

Gilbert N. Tanner-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10009 Old Franklin Avenue, Seabrook, MD 20706

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Funeral Services Inc. 4/9/97

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home  
9013 Annapolis Road, Lanham, MD 20706

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic breast carcinoma

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Barry K. Lance, M.D. - Attending physician

29c. License number

D 27733

29d. Date signed (Month, Day, Year)

4/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry K. Lance, M.D., 14201 Laurel Park Dr., # 214, Laurel, MD 20707

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

John A. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 12858

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elmer Michael Tilghman

2. Date of Death

Month Day Year  
April 6, 1997

3. Time of Death

5:15 P.M.

4a. Facility Name (If not institution, give street and number)

7014 Independence Street

4b. City, Town, or Location of Death

Capitol Hgts. Prince George's

4c. County of Death

Funeral  
Director

5. Social Security Number

216-40-5019

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12/6/41

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Capitol Hgts.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7014 Independence St.

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Loader

16b. Kind of Business/Industry

Safeway Foods

17. Father's Name (First, Middle, Last)

Elmer M. Tilghman, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Nichols

19a. Informant's Name/Relationship (Type, Print)

Barbara L. Tilghman/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as # 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

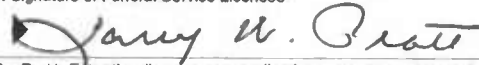
Harmony Mem. Park 4/12/97

Date

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

H.S. Washington & Sons, Inc.  
4925 Burroughs Ave., N.E.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

CONGESTIVE HEART FAILURE

e. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Diabetes mellitus

Cerebrovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide  
6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

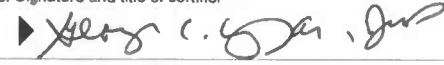
M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

039550

29d. Date signed (Month, Day, Year)

April 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George C. Hajjar, Jr. M.D.

4850 Forbes Blvd., Lanham, Md. 20706

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12859

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Louise Tayman

2. Date of Death

April 1, 1997

3. Time of Death

2:16pm

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

218-01-8115

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 5, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Charles's

10c. City, Town or Location

La Plata

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1 Hickory Lane

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Air Products

17. Father's Name (First, Middle, Last)

Albert Moore

18. Mother's Name (First, Middle, Maiden Surname)

Laura Wagoner

19a. Informant's Name/Relationship (Type, Print)

T. Dale Neaves - Son-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7305 Simms Landing Road, Port Tobacco, MD 20677

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

4/4/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Claudette J. Gasch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

George Wathen

29c. License number

D- 20629

29d. Date signed (Month, Day, Year)

4/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Wathen, MD 11345 Pembroke Square, Suite 103, Waldorf, Maryland 20602

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

John Andrew Radell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12860

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Olga I. Turin

2. Date of Death

March 31, 1997

3. Time of Death

1:45 PM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

9507 Flower Avenue

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

544-34-8550

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 14, 1904

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9507 Flower Avenue

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Publishing

17. Father's Name (First, Middle, Last)

John Weinglass

18. Mother's Name (First, Middle, Maiden Surname)

Eugenia Buchvostova

19a. Informant's Name/Relationship (Type, Print)

Nick Turin / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9507 Flower Avenue, Silver Spring, Maryland 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Creek Cemetery

Date

4/2/97

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Heart Failure

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Obesity

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Degenerative Joint Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Faruk Ozer, M.D.

29c. License number

D16409

29d. Date signed (Month, Day, Year)

April 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Faruk T. Ozer, M.D. 11125 Rockville Pike, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12861

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ANTIGONI IOANNIS TSITOURIS</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 2, 1997</b>   |  | 3. Time of Death<br><b>10:40 PM</b>                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Circle Manor Nursing Home</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Kensington</b>  |  | 4c. County of Death<br><b>Montgomery</b>                                |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>224-74-0751</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug 23, 1906</b>              |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Greece</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Gaithersburg</b>                      |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>9551 Horizon Run Road</b>  |  | 10f. Zip Code<br><b>20879</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Aristidis Tsitouris</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alexandra Kritselis</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>John Billos, Grandson</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9551 Horizon Run Road, Gaithersburg, MD 20879</b>  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>   |  | Date<br><b>Apr. 5, 1997</b>  |  | 20c. Location - City or Town, State<br><b>Rockville, MD</b>             |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Dr., Gaithersburg, MD 20877</b>  |  |   |  |
|  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>3 DAYS</b> |  |   |  |  |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |  |   |  |
| 29b. Signature and Title of Certifier<br>  |  |  |   | 29c. License number<br><b>D34032</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 3, 1997</b>                          |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JEANNE P. ASHER, M.D., 3720 FARRAGUT AVENUE, KENSINGTON, MARYLAND 20895-2110</b>  |  |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 08 1997</b>  |  |  |   | 32. Registrar's Signature<br>  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12862

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM PAUL Thien</b>   |   | 2. Date of Death<br>Month Day Year<br><b>April 12, 1997</b>   |  | 3. Time of Death<br><b>8:26 AM</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital @ Easton</b>   |   | 4b. City, Town, or Location of Death<br><b>Easton</b>   |  | 4c. County of Death<br><b>Talbot</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>057-03-1100</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 20, 1911</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>WISCONSIN</b>  |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   | 10c. City, Town or Location   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 10a. State<br><b>MD</b>   | 10b. County<br><b>TALBOT</b>  | <b>TRAPPE</b>   |  |  |
|  | 10e. Street and Number<br><b>29292 WEST MAPLE AVENUE</b>  |   | 10f. Zip Code<br><b>21673</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>             |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MARINE MECHANIC</b>   |   | 16b. Kind of Business/Industry<br><b>MARINE/BOATYARD</b>  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>BRUNO WILHELM THIEN</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FREDA SCHROEDER</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LOIS THIEN KEEN/DAUGHTER</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>600 HAVEN ST., J 17, EVANSTON, IL 60201</b>   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CENTER, I.L.C.</b>                              |  | 20c. Location - City or Town, State<br><b>4-14-97 CHESTER, MD</b>  |
|  | 21. Signature of Funeral Service Licensee<br><b>Joseph M. Ostrowski</b>   |   | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD 21601</b>                |  |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |   |   |  | Approximate Interval Between Onset and Death   |
|  | Immediate Cause (Final disease or condition resulting in death)<br><b>pneumonia, right lower lobe</b>   |   |   |  | <b>days</b>  |
|  | Due to (or as a consequence of):  |   |   |  |  |
|  | <b>lung cancer, small cell</b>  |   |   |  | <b>2 years</b>   |
|  | Due to (or as a consequence of):  |   |   |  |  |
|  | Due to (or as a consequence of):  |   |   |  |  |
|  | Due to (or as a consequence of):  |   |   |  |  |
|  | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29c. License number<br><b>D47311</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/12/97</b>  |  |
| 29b. Signature and title of certifier<br><b>Suzanne W. Neimela</b>   |   |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SUZANNE W. NEIMELA, M.D., 606 DUTCHMAN'S LANE, EASTON, MD 21601</b>   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12863

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |  |   |  |   |  |                                      |  |   |  |
|--|--|--|---|--|---|--|--|---|--|---|--|--------------------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>SHIRLEY MAE THOMPSON</b>  |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 12, 1997</b>                    |   |  | 3. Time of Death<br><b>4:20 AM</b>   |   |  |   |  |                                      |  |   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>8482 AVALEY FARMS ROAD</b>  |  |   | 4b. City, Town, or Location of Death<br><b>EASTON</b>                          |   |  | 4c. County of Death<br><b>TALBOT</b>   |   |  |   |  |                                      |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-54-9946</b>  |  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>46</b>                                  |  | 8. Date of Birth (Month, Day, Year)<br><b>AUGUST 16, 1950</b>           |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |                                      |  |   |  |
|  | Usual Residence of Decedent  |  |   |  |   |  |  |   |  |   |  |                                      |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>TALBOT</b>  |  | 10c. City, Town or Location<br><b>EASTON</b>  |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |                                      |  |   |  |
|  | 10e. Street and Number<br><b>8482 AVALEY FARMS ROAD</b>  |  |   |  | 10f. Zip Code<br><b>21601</b>   |  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |   |  |                                      |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |  |                                      |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PROFESSOR</b>   |  |  | 16b. Kind of Business/Industry<br><b>EDUCATION</b>                      |  |   |  |                                      |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>EDWARD EARL SMITH</b>  |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>GLADYS MANSFIELD</b> |  |   |  |   |  |                                      |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DONALD W. THOMPSON, JR.</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8482 AVALEY FARMS ROAD, EASTON, MD 21601</b>  |  |  |   |  |   |  |                                      |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>STEVENSVILLE CEMETERY</b>  |  | Date<br><b>4-15</b>  |   | 20c. Location - City or Town, State<br><b>STEVENSVILLE, MD</b>                                     |   |  |                                      |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>John R. MERCER</b>   |  |   |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD</b>  |  |  |   |  |   |  |                                      |  |   |  |
|  | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. <i>Dissecting aortic aneurysm</i></b><br>Due to (or as a consequence of):             |  |   |  |   |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>13 Mos.</b> |                                      |  |   |  |
|  | 23a. Pert 2. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. _____</b><br>Due to (or as a consequence of):<br><b>c. _____</b><br>Due to (or as a consequence of):<br><b>d. _____</b> |  |   |  |   |  |  |   |  |   |  |                                      |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |                                      |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                                      |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                      |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |   |  |                                      |  |   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |  |   |  |                                      |  |   |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |   |  |  |   |  | 29b. Signature and title of certifier<br><b>David H. Smith</b>  |  | 29c. License number<br><b>D39887</b> |  | 29d. Date signed (Month, Day, Year)<br><b>4/14/97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>509 Idlewild Ave Easton MD 21601</b>  |  |  |   |  |   |  |  |   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DAVID H. SMITH, M.D.</b>   |  |                                      |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>  |  |  | 32. Registrar's Signature<br><b>David H. Smith</b>  |  |   |  |  |   |  |   |  |                                      |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12864

## Certificate of Death

Reg. No.

|   |   |  |  |   |  |  |  |  |
|---|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Neoma Faye Ursano</b>  |  |  |   | 2. Date of Death<br>Month <b>04</b> Day <b>04</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>0722</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3900 Cleveland Street</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>Kensington</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>431-18-8095</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>09-28-1920</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Arkansas</b>   |  | 10e. State<br><b>Virginia</b>  |   | 10b. County<br><b>Fairfax</b>  |  | 10c. City, Town or Location<br><b>Alexandria</b>   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent<br>10e. State <b>Virginia</b> 10b. County <b>Fairfax</b> 10c. City, Town or Location <b>Alexandria</b>  |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10f. Zip Code<br><b>22309</b>  |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                       |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>02</b>                   |  |
|   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Lealon F. Summers</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Centhye E. Barker</b>   |  |  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert J. Ursano</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3900 Cleveland Street Kensington, Maryland 20895</b> |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cem.</b>   |  | 20c. Location - City or Town, State<br><b>4/10/97 Arlington, Virginia</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |  |   | 22. Name and Address of Facility<br><b>Demaine Funeral Homes, Inc.</b><br><b>520 S. Washington St., Alexandria, Virginia 22314</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>BREAST Cancer</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |  |   | Approximate Interval Between Onset and Death<br><b>33 mo</b>   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   |  |  | 28a. Date of Injury (Month, Day, Year)<br><b>04/10/97</b>   |  |  |  |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |
| 28d. Describe how injury occurred   |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  |  | 29c. License number<br><b>D32671 (MD)</b>   |  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>10 APR 97</b>   |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Hematology Oncology Svc WALTER REED, WASH D.C.</b>   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 11 1997</b>   |   |  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12865

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Louise VANE

2. Date of Death

Month Day Year  
March 31, 1997

3. Time of Death

11:05PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctors' Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

578 36 8691

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 21 1930

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8665 Greenbelt Road

10f. Zip Code

20770

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 52/56

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

18b. Kind of Business/Industry

Special Ed

17. Father's Name (First, Middle, Last)

Ralph Stafford

18. Mother's Name (First, Middle, Maiden Surname)

Mabel McClure

19a. Informant's Name/Relationship (Type, Print)

Christopher Vane Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1911 R. Street N.W. Washington D.C. 20009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 4/4/97 Cheltenham Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.  
16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyponatremia

Hypercalcemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D16410

29d. Date signed (Month, Day, Year)

April 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gabriel Jaffe, MD

7500 Hanover Parkway, Suite 105, Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12866

## Certificate of Death

Reg. No.

|  |  |                                  |   |   |  |                                      |   |  |   |  |
|--|--|----------------------------------|---|---|--|--------------------------------------|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Catherine C. Wagner</i>                             |                                  |   |   |  |                                      | 2. Date of Death<br>Month <i>4</i> Day <i>12</i> Year <i>97</i>                             |  | 3. Time of Death<br><i>5 45 Am</i>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Avalon Manor Nursing Home</i> |                                  |   |   |  |                                      | 4b. City, Town, or Location of Death<br><i>Hagerstown MD</i>                                |  | 4c. County of Death<br><i>Washington</i>                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>214-07-2817</i>  |                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>83</i> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.       | 8. Date of Birth (Month, Day, Year)<br><i>Nov. 26, 1914</i>                                 |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i> |  |
|  | Usual Residence of Decedent  |                                  |   |   |  |                                      |   |  |   |  |
| 10a. State<br><i>Maryland</i>  |  | 10b. County<br><i>Washington</i> |   | 10c. City, Town or Location<br><i>Williamsport</i>  |  |                                      |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><i>Milestone Garden Apt 5A</i>   |  |                                  |   |   | 10f. Zip Code<br><i>21795</i>  |                                      | 10g. Citizen of What Country?<br><i>U.S.A.</i>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                      |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>white</i>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>0-6</i> College (1-4or 5+) <i>0</i>  |  |                                  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>homemaker</i> |  |                                      | 16b. Kind of Business/Industry<br><i>own home</i>   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><i>Owen Carter</i>  |  |                                  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Clara</i>  |                                      |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Mrs. Linda Abe</i>  |  |                                  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1401 Haven Road, D22, Hagerstown, Maryland 21742</i>                                     |                                      |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Hagerstown Crematory</i>   |   | Date<br><i>4-13-97</i>   |                                      | 20c. Location - City or Town, State<br><i>Hagerstown, Maryland</i>                          |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Scott Minnich</i>  |  |                                  |   |   | 22. Name and Address of Facility<br><i>Minnich Funeral Home<br/>415 East Wilson Blvd., Hagerstown, Maryland 21740</i>  |                                      |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <i>congestive heart failure</i><br>Due to (or as a consequence of):<br><br>b. <i>chronic obstructive lung disease</i><br>Due to (or as a consequence of):<br><br>c. <i>severe scoliosis</i><br>Due to (or as a consequence of):<br><br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>b.<br>c.<br>d.<br><br>Approximate Interval Between Onset and Death<br><i>one week</i><br><i>unknown</i><br><i>unknown</i> |  |                                  |   |   |  |                                      |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Atherosclerosis</i><br><i>Senile dementia</i>   |  |                                  |   |   |  |                                      |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |                                  |   |   |  |                                      |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                      |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |                                      |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |                                  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><i>M</i>  |                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred                           |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                                  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  | 29c. License number<br><i>D44996</i> |   | 29d. Date signed (Month, Day, Year)<br><i>April 12, 1997</i>                                   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>ZAFAR MALIK 20311 Lappans Rd Boonsboro MD 21713.</i>  |  |                                  |   |   |  |                                      |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 15 1997</i>  |  |                                  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |                                      |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12867

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

JOYCE LOUISE WHITE

2. Date of Death

Month Day Year  
APRIL 10 1997

3. Time of Death

4:02 AM

4a. Facility Name (If not institution, give street and number)

WILLIAMSPORT NURSING HOME

4b. City, Town, or Location of Death

WILLIAMSPORT

4c. County of Death

WASHINGTON

5. Social Security Number

213-42-1644

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

NOV. 25, 1942

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

MAUGANSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

13817 VILLAGE MILL DRIVE

10f. Zip Code

21767

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WAITRESS

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

RALPH LEWIS LORSHBAUGH

18. Mother's Name (First, Middle, Maiden Surname)

GOLDIE BELLE STAINS

19a. Informant's Name/Relationship (Type, Print)

P. JOSEPH WHITE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13817 VILLAGE MILL DRIVE MAUGANSVILLE, MD.

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HAGERSTOWN CREMATORY 4/14/97 HAGERSTOWN, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Gerald N. Minnich*

22. Name and Address of Facility

GERALD N. MINNICH  
FUNERAL HOME305 N. POTOMAC STREET  
HAGERSTOWN, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Carcinoma.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

One year

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA ☒ Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D44996

29d. Date signed (Month, Day, Year)

April 14, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Zafar Malik MD 20311 Lappans Rd Boonsboro MD 21713

31. Date filed (Month, Day, Year)

APR 15 1997

32. Registrar's Signature

*[Signature]*State  
Registrar

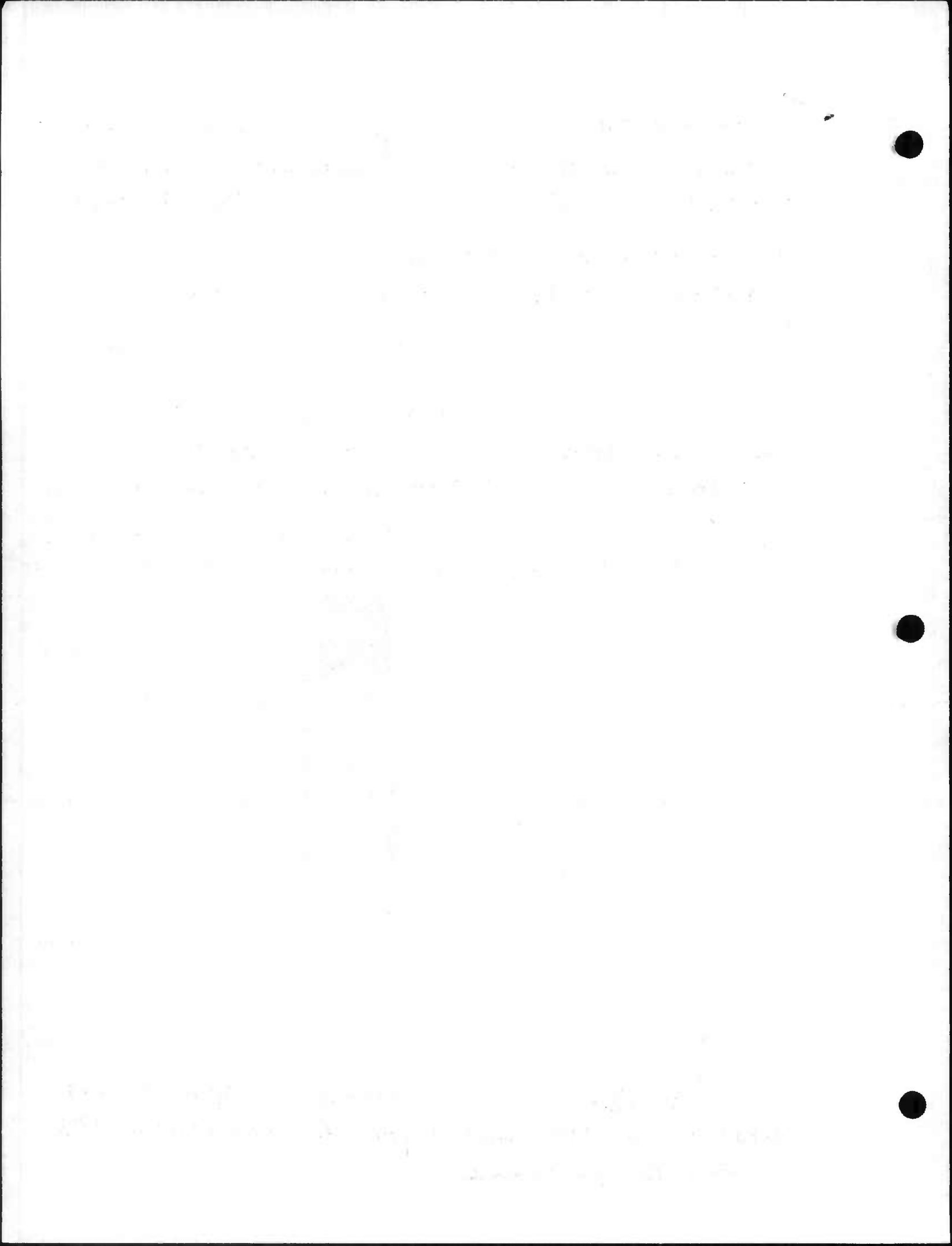
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12868

## Certificate of Death

Reg. No.

|                                     |  |  |   |  |   |  |  |  |
|-------------------------------------|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LEROY CLARENCE WILL</b>   |  | (Wills)   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 14, 1997</b>   |  | 3. Time of Death<br><b>7:10 AM</b>   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>3 AMBLESIDE COURT</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BERLIN</b>   |  | 4c. County of Death<br><b>WORCESTER</b>  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>188-07-2556</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>7-25-12</b>  |  |
|                                     | 9. Birthplace (State or Foreign Country)<br><b>PA.</b>   |  | 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>WORCESTER</b>   |  | 10c. City, Town or Location<br><b>BERLIN</b>   |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3 AMBLESIDE CT.</b>  |  | 10f. Zip Code<br><b>21811</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRUCK DRIVER</b>  |  | 16b. Kind of Business/Industry<br><b>PLUMBING</b>   |  |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>RICHARD C. WILL</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY JANE LOCKETT</b>   |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARGARET H. WILLS</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3 AMBLESIDE CT., BERLIN, MD., 21811</b>   |  |  |  |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SALISBURY CREMATORY</b>  |  | 20c. Date<br><b>4-15</b>  |  | 20d. Location - City or Town, State<br><b>SALISBURY, MD., 21811</b>  |  |
|                                     | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>ULLRICH FUNERAL HOME BERLIN, MD.</b>   |  |   |  |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>10 years</b> |  |   |  |   |  |  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>asthma</b>  |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                     |  |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|                                     |  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| Physician<br>/Medical<br>Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|                                     |  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><i>[Signature]</i><br><b>physician</b>   |  | 29c. License number<br><b>H44283</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/14/1997</b>  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR Durkin, 9733 Heathway Dr, Berlin MD 21811</b>  |  |   |  |   |  |  |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>APR 15 1997</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12869

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |   |
|--|---|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>James B White Sr.</i>                                |   | 2. Date of Death<br>Month <i>April</i> Day <i>8</i> Year <i>1997</i> |  | 3. Time of Death<br><i>10:22 P.M.</i>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Southern Maryland Hospital</i> |   | 4b. City, Town, or Location of Death<br><i>Clinton</i>               |  | 4c. County of Death<br><i>Prince George's</i>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><i>183-16-5990</i>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>79</i> Yrs.                     | If Under 1 Year<br>Months <i>0</i> Days <i>0</i>   | If Under 24 Hrs.<br>Hours <i>0</i> Min. <i>0</i>   | 8. Date of Birth (Month, Day, Year)<br><i>2/19/18</i>                   |
|  | Usual Residence of Decedent<br>10a. State <i>Maryland</i> 10b. County <i>Prince George's</i>        |   | 10c. City, Town or Location<br><i>Temple Hills</i>                   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><i>5009 Henderson Rd.</i>  |   | 10f. Zip Code<br><i>20748</i>   |  | 10g. Citizen of What Country?<br><i>USA</i>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>WWII</i>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>7th</i> College (1-4 or 5+) <i>0</i>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Driver/Deliveryman</i>  |  | 16b. Kind of Business/Industry<br><i>Safeway Food Stores</i>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><i>James Henry White</i>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Neta Durette</i>  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Kate M. White/Wife</i>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>same as item 10</i>   |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Maryland Veteran's Cemetery</i>  |  | Date <i>4/15/97</i> 20c. Location - City or Town, State<br><i>Cheltenham, Md.</i>  |  |   |
| 21. Signature of Funeral Service Licensee<br><i>George P. Kalas</i>  |   | 22. Name and Address of Facility<br><i>George P. Kalas Funeral Home</i><br><i>6160 Oxon Hill Rd. Oxon Hill, Md. 20745</i>   |  |  |  |   |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Sudden Cardiac Death</i><br>Due to (or as a consequence of):<br><i>Ventricular Fibrillation</i><br>Due to (or as a consequence of):<br><i>Arteriosclerotic Heart Disease</i><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death  |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |  |   |
|  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |   |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br><i>Richard McConaughy MD</i>   |  | 29c. License number<br><i>D07287</i>   |  |   |
|  |   | 29d. Date signed (Month, Day, Year)<br><i>April 9, 1997</i>   |  |  |  |   |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><i>Richard McConaughy MD 11418 Livingston Rd. Fort-Wash.</i>   |   |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><i>APR 10 1997</i>  |   | 32. Registrar's Signature<br><i>John D. Parker</i>  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





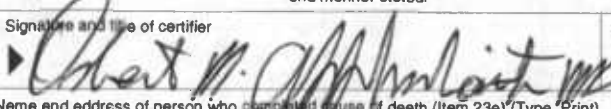
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 12870

Reg. No.

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Juanita Williamson   |  |  |  | 2. Date of Death<br>Month Day Year<br>April 7, 1997  |  | 3. Time of Death<br>11:00 AM   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>220 Panorama Dr.   |  |  |  | 4b. City, Town, or Location of Death<br>Oxon Hill  |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director   | 5. Social Security Number<br>219-42-4945   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>85 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>7/12/11   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Eufaula, Oklahoma  |  | 10a. State<br>Maryland   |  | 10b. County<br>Prince George's   |  | 10c. City, Town or Location<br>Oxon Hill   |  |
| To Be Completed by Funeral Director   | 10e. Street end Number<br>220 Panorama Dr.   |  | 10f. Zip Code<br>20745   |  | 10g. Citizen of What Country?<br>USA   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher                       |  | 16b. Kind of Business/Industry<br>School System  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Charles W. Jeffress   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rose Park   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Earl W. Williamson, Jr./Son  |  |  |  | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)<br>same as item 10   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>National Memorial Park   |  | Date<br>4/12/97  |  | 20c. Location - City or Town, State<br>Falls Church, Va.                                       |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br>George P. Kalas Funeral Home<br>6160 Oxon Hill Rd. Oxon Hill, Md. 20745  |  |  |  |
|   | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Multiple Myeloma<br>Due to (or as a consequence of):<br>b. Fractured Right Femur<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertensive Atherosclerotic Cardiovascular Disease<br>Osteoporosis  |  |  |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 28a. Date of Injury (Month, Day, Year)   |  |  |  |  |  |  |  |
|   | 28b. Time of Injury<br>M   |  |  |  |  |  |  |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |  |  |
|   | 28d. Describe how injury occurred  |  |  |  |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |  |  |  |  |  |  |  |
| 29c. License number<br>D-21507  |  |  |  |  |  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br>April 8, 1997  |  |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Osbert M. Applewhite, M.D. 6196 Oxon Hill Rd. #445, Oxon Hill, Md. 20745  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 10 1997  |  |  |  |  |  |  |  |  |
| 32. Registrar's Signature<br>  |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 12871

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Jane Wilson

2. Date of Death

Month Day Year  
April 6, 1997

3. Time of Death

7:30 P.M.

4a. Facility Name (If not institution, give street and number)

Regency Nursing Home

4b. City, Town, or Location of Death

Forestville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-056956

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 11, 1906

9. Birthplace (State or Foreign Country)

Sylvan, Md.

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7420 Marlboro Pike

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Internal Revenue Service

17. Father's Name (First, Middle, Last)

Martin Shives

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Ward

19a. Informant's Name/Relationship (Type, Print)

Charles Wilson, Jr.-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10911 Exeter Court, Upper Marlboro, Md. 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

4/9/1997

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

Francis Gasch's Sons Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, Md. 20781

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, Md. 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Alzheimer

Due to (or as a consequence of):

b.

Aspiration pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael G. Sedarous

29c. License number

D45365

29d. Date signed (Month, Day, Year)

4-7-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael G. Sedarous 11701 - Livingston Rd. Ft. Wash, MD 20744

31. Date filed (Month, Day, Year)

APR 09 1997

32. Registrar's Signature

John A. Swanson-Russell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12872

## Certificate of Death

Reg. No.

|   |  |   |  |   |  |   |   |  |
|---|--|---|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret L. Webster</b>                               |   |  |   | 2. Date of Death<br>Month <b>April</b> Day <b>6</b> Year <b>1997</b> |   | 3. Time of Death<br><b>6:35 PM</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Doctors' Community Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Lanham</b>                |   | 4c. County of Death<br><b>Prince George's</b>               |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-03-6821</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs.) last birthday<br><b>87</b> Yrs.                     |   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 22, 1910</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, Md.</b>                                    |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince Georges</b>                                 |   | 10c. City, Town or Location<br><b>Hyattsville</b>           |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>5821 Queens Chapel Road</b>  |  | 10f. Zip Code<br><b>20782</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerical</b>                      |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William F. Liedlich</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Noel</b>  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert N. Bowers / Son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>901 Kaster Arch Virginia Beach, Virginia 23455</b>  |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Location - City or Town, State<br><b>4-8-97 Alexandria, Virginia</b>   |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Shannon W. Raming</b>   |  |   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.<br/>16000 Annapolis Road Bowie, Maryland 20715</b>  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>b. ISCHEMIC HEART DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>CHRONIC ATRIAL FIBRILLATION</b><br><b>PROTEIN C DEFICIENCY</b><br><b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b> |  |   |  |   |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Norman K. Bohner</b>  |  |   |  | 29c. License number<br><b>D00574</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 7, 1997</b>                                 |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>3231 SUPERIOR LANE AVE BOWIE, MD 20715</b>   |  |   |  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 11 1997</b>   |  |   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,









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State of Maryland / Department of Health and Mental Hygiene

97 12874

## Certificate of Death

Reg. No.

|  |   |   |   |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|--|---|---|---|--------------------------------|--|--|--|--|---|----|-------------|----------------------------------|--|----|--------------------|----|--|----|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Dorothea D. Walker  |   |   |                                | 2. Date of Death<br>Month Day Year<br>April 1, 1997  |  | 3. Time of Death<br>2:00 P.M.                                    |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | 4a. Facility Name (If not Institution, give street and number)<br>Rockville Nursing Home  |   |   |                                | 4b. City, Town, or Location of Death<br>Rockville  |  | 4c. County of Death<br>Montgomery                                |  |   |    |             |                                  |  |    |                    |    |  |    |
| Funeral<br>Director  | 5. Social Security Number<br>276-20-7812  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>95 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Sept. 5, 1901   |  | 9. Birthplace (State or Foreign Country)<br>Ohio   |   |    |             |                                  |  |    |                    |    |  |    |
|  | Usual Residence of Decedent   |   |   |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
| To Be Completed by<br>Funeral Director   | 10a. State<br>Maryland  | 10b. County<br>Montgomery   | 10c. City, Town or Location<br>Potomac  |                                |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | 10e. Street and Number<br>10700 Stanmore Drive  |   |   | 10f. Zip Code<br>20854         |  | 10g. Citizen of What Country?<br>United States   |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4  |   | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                |                                | 16b. Kind of Business/Industry<br>Own Home   |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | 17. Father's Name (First, Middle, Last)<br>Edward Doller  |   |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Anna Diehl  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
| To Be Completed by<br>Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Dorothea W. Dressler / Daughter   |   |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10700 Stanmore Drive, Potomac, Maryland 20854   |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Knollwood Cemetery/April 4, 1997  |                                | 20c. Location - City or Town, State<br>Cleveland, Ohio   |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | 21. Signature of Funeral Service Licensee<br><i>Michael P. Kutta</i> M00348   |   | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/<br>Rockville, Inc., 300 W. Montgomery Avenue<br>Rockville, Maryland 20850-2805   |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Dehydration</td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4"></td> </tr> <tr> <td>b.</td> <td>Failure to Urinate</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |   |                                |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. | Dehydration | Due to (or as a consequence of): |  | b. | Failure to Urinate | c. |  | d. |
| Immediate Cause (Final disease or condition resulting in death)  | a.  | Dehydration   | Due to (or as a consequence of):  |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | b.  | Failure to Urinate  |   |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | c.  |   |   |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|  | d.  |   |   |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |                                |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |   |    |             |                                  |  |    |                    |    |  |    |
|  |   |   |   |                                |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |    |             |                                  |  |    |                    |    |  |    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28e. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M       |  | 28c. Injury et Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   |    |             |                                  |  |    |                    |    |  |    |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |    |             |                                  |  |    |                    |    |  |    |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
| 29b. Signature and title of certifier<br><i>R. Shaker</i>  |   |   |   | 29c. License number<br>D27830  |  | 29d. Date signed (Month, Day, Year)<br>April 1, 1997   |  |  |   |    |             |                                  |  |    |                    |    |  |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Ramleth Shakir, M.D., 9019 Shady Grove Court, Gaithersburg, MD 20877   |   |   |   |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |
| 31. Date filed (Month, Day, Year)<br>APR 07 1997   |   | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |   |                                |  |  |  |  |   |    |             |                                  |  |    |                    |    |  |    |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12875

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anne M. Wimmel

2. Date of Death

Month Day Year  
April 2, 1997

3. Time of Death

4:50 P.M.

4a. Facility Name (If not institution, give street and number)

Maplewood Park Place

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

577-03-6152

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 3, 1911

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9707 Old Georgetown Road

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jacob Stickel

18. Mother's Name (First, Middle, Maiden Surname)

Anna Loeffler

19a. Informant's Name/Relationship (Type, Print)

James T. Wimmel / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7707 13th Street, N.W., Washington, DC 20012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

April 5, 1997  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Michael P. Lutter M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.  
Bethesda, Maryland 20814-3501

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiopulmonary arrest*  
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Cerebral systolic infarct*  
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P23125

29d. Date signed (Month, Day, Year)

April 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MK MOWAN M.D 6504 Kenilworth Ave #200 Riverdale

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

Julia Davidson-Randall

md - 20137

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12876

ITEM#5 PER F.H. FLM#G&amp;47 5/16/97 J.A.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Adelaide A. Wermter

2. Date of Death

Month Day Year  
April 6, 1997

3. Time of Death

11:38 PM

4e. Facility Name (If not institution, give street end number)

Manor Care - Bethesda

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

128-22-5837

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 22, 1929

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street end Number

3915 Denfeld Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Maurice Blake

18. Mother's Name (First, Middle, Maiden Surname)

Delia Hughes

19e. Informant's Name/Relationship (Type, Print)

Joan M. Mattingly

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

3915 Denfeld Avenue Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cemetery

Date

4/14/97

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Eric J. Scarbo

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bronchopneumonia

Due to (or as a consequence of):

days

b. Parkinson's Disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ ODA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lee Jonathan Musher MD

29c. License number

D33357

29d. Date signed (Month, Day, Year)

4/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee Jonathan Musher MD 5530 Wisconsin Ave Chevy Chase MD 20815

31. Data filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12877

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>DOROTHY LOUISE WILSON-MOY</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 5 1997</b>  |  | 3. Time of Death<br><b>1.25 AM</b>  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>138-40-3604</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 17, 1949</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Gaithersburg</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>242 Gold Kettle Drive</b>  |  | 10f. Zip Code<br><b>20878</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Co-Founder &amp; Owner</b>            |  | 16b. Kind of Business/Industry<br><b>Telecommunications Consulting Company</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Robert B. Wilson</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen D. Mansfield</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>George Moy, Jr. / Husband</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>242 Gold Kettle Drive, Gaithersburg, MD 20878</b> |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>   |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>   |  | 20d. Date<br><b>April 12, 1997</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Michelle P. Ketter</i> M00348   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850-2805</b> |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. MALIGNANT PLEURAL EFFUSION</b><br>Due to (or as a consequence of):<br><b>b. METASTATIC BREAST CANCER</b><br>Due to (or as a consequence of):<br><b>c. EXTENSIVE LUNG METASTASES.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day, Year)<br><b>28b. Time of Injury</b> M <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>28d. Describe how injury occurred</b><br><b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  | 29b. Signature and title of certifier<br><i>May June Maheshwari M.D.</i>   |  |   |  |
|   | 29c. License number<br><b>D-44025</b>   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>4/15/97</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. LINDA M. THOMPSON M.D.</b>  |  |   |  | 31. Date filed (Month, Day, Year)<br><b>APR 10 1997</b>  |  |   |  |
|   | 32. Registrar's Signature<br><i>John Davidson-Rendell</i>   |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12878

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD

WEBSTER

2. Date of Death

APRIL 7, 1997

3. Time of Death

8:15 p.m.

4a. Facility Name (If not institution, give street and number)

6818 TILDEN LANE

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

214-10-0432

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 29, 1920

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6818 Tilden Lane

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

Richard Custis Webster

18. Mother's Name (First, Middle, Maiden Surname)

Kathrine Mattingly

19a. Informant's Name/Relationship (Type, Print)

Judith T. Webster

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6818 Tilden Lane, Bethesda, MD 20852

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Comfort Crematory

Date

4/11/97

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Joseph Gawler's Sons, Inc.  
5130 Wisconsin Avenue, NW, Washington, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Refractory Anemia

Approximate Interval Between Onset and Death

2 years

e. Due to (or as a consequence of):

Myelofibrosis of Bone Marrow

3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

DC 6104

29d. Date signed (Month, Day, Year)

April 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas C. Havell, II M.D. 4201 Cathedral Ave. NW, Washington, D.C. 20016

31. Date filed (Month, Day, Year)

APR 10 1997

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Cleared by Maryland M.E. Dr. Mayle  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12879

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Mabel Pierce Williams

2. Date of Death  
Month Day Year  
APRIL 16 1997

3. Time of Death  
14:10

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

215-20-6087

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

8. Date of Birth (Month, Day, Year)

Sept 10, 1904

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12313 Amherst Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse Supervisor

16b. Kind of Business/Industry

Nursing Home

17. Father's Name (First, Middle, Last)

Charles Pierce

18. Mother's Name (First, Middle, Maiden Surname)

Nelle Elizabeth (Barnes)

19a. Informant's Name/Relationship (Type, Print)

Paula E. Munson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

36 Frost Ave., Frostburg, MD. 21532

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

4/19/97

20c. Location - City or Town, State

Cumberland, Maryland

21. Signature of Funeral Service Licensee

*W. H. H. H.*

22. Name and Address of Facility

Kight Funeral Home

309-311 Decatur St., Cumberland, MD. 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Coronary Heart failure*  
Due to (or as a consequence of):  
b. *Ischemic Myocardial infarction*  
Due to (or as a consequence of):  
c.   
Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

3 days  
2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Ruptured intra-abdominal  
viscus*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*G. L. Wagoner*

29c. License number

D22181

29d. Date signed (Month, Day, Year)

APRIL 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gary L. Wagoner, 925 Bishop Walsh Road, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

APR 18 1997

32. Registrar's Signature

*John Davidson Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



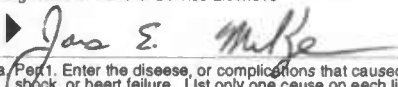
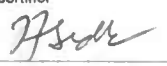

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12880

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |  |  |
|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS HARRISON WILT</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 12 1997</b>  |  | 3. Time of Death<br><b>9:30 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  | 4c. County of Death<br><b>Allegany</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>215-34-2599</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 29, 1935</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Lonaconing</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>21318 Charlestown Rd.S.W.</b>   |  | 10f. Zip Code<br><b>21539</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:          |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Warehouse</b>                              |  | 16b. Kind of Business/Industry<br><b>Paper</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Thomas O. Wilt</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Thelma M. Beeman</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Phyllis J. Wilt</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21318 Charlestown Rd.S.W., Lonaconing, Md. 21539</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>April 15, 1997 Lonaconing, Md.</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Eichhorn-McKenzie Funeral Home<br/>Lonaconing, Md. 21539</b>   |  |  |  |
|   | 23a. Pert. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>METASTATIC CARCINOMA OF COLON</b><br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>5 years</b><br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                 |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D26907</b>   |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>APRIL 13 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>HARJIT SIDHU M.D. 925 BISHOP WALSH ROAD CUMBERLAND MD 21502</b> |  | 31. Date filed (Month, Day, Year)<br><b>APR 16 1997</b>   |  | 32. Registrar's Signature<br> |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12881

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JACKSON YOUNG

2. Date of Death

Month Day Year  
March 26, 1997

3. Time of Death

7:45 PM

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF KENSINGTON

4b. City, Town, or Location of Death

KENSINGTON

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

250-12-3211

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
May 16, 1918

9. Birthplace (State or Foreign Country)

BAMBERG, S.C.

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1616 Marion St., N.W.

10f. Zip Code

20001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
5th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pulpwood Cutter

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Zack Young

18. Mother's Name (First, Middle, Maiden Surname)

Banner Hightower

19a. Informant's Name/Relationship (Type, Print)

Hester Robinson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

926 5th Ave., Charleston S.C. 29407

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Capernaum Baptist Cem

Date

4/5/97

20c. Location - City or Town, State

Denmark, S.C.

21. Signature of Funeral Service Licensee

Bebra J. Jenkins

22. Name and Address of Facility

Johnson &amp; Jenkins Inc.

716 Kennedy St., N.W. Wash. D.C. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ARRHYTHMIA

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 MINUTES

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBRO-VASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

T. J. Anthony, MD

29c. License number

J50300

29d. Date signed (Month, Day, Year)

MARCH 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS J ANTHONY, MD, 11119 ROCKVILLE PIKE #316, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

APR 08 1997

32. Registrar's Signature

Julia Anderson-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12882

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Oscar Sylvester

Yates

2. Date of Death

Month  
AprilDay  
15Year  
1997

3. Time of Death

1:00pm

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

214-24-0774

6. Sex

M 20 F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

Aug. 3 1918

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Newburg

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

13055 Mt. Victoria Rd.

10f. Zip Code

20664

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Grant Yates

18. Mother's Name (First, Middle, Maiden Surname)

Ida Green Yates

19a. Informant's Name/Relationship (Type, Print)

Joseph M. Yates

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11455 Crain Highway Newburg, MD 20664

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Mary's Church Cem. 4/19/97 Newport, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

David C. Elton

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, INC.

MO0945 P.O. Box 567 LaPlata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. metastatic prostate cancer to lung and bone

Approximate  
Interval Between  
Onset and Death

1 year

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. obstructive uropathy

2 year

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?  
1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
2 Accident 6 Investigation  
3 Suicide 6 Could not be  
4 Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Oswald Hays

29c. License number

D - 26352

29d. Date signed (Month, Day, Year)

4/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oswald Hays, MD 9131 Piscataway Road, Suite 540, Clinton, Maryland 20735

31. Date filed (Month, Day, Year)

APR 18 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

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State of Maryland / Department of Health and Mental Hygiene

97 12883

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie Mae Zell

2. Date of Death

Month Day Year  
April 2, 1997

3. Time of Death

4:54 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Larkin Chase Nursing &amp; Restorative Center

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

5. Social Security Number

212-14-8644

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 3, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Brentwood

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3706 Perry Street

10f. Zip Code

20722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

State Government

17. Father's Name (First, Middle, Last)

Howard William Loy

18. Mother's Name (First, Middle, Maiden Surname)

Addie Frances Best

19a. Informant's Name/Relationship (Type, Print)

Nancy Dillon - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3680 Wessex Lane, Huntingtown, Maryland 20639-8700

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Evergreen Cemetery

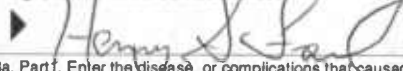
Date

4/5/97

20c. Location - City or Town, State

Bladensburg, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ? CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

b. RENAL FAILURE

Due to (or as a consequence of):

c. CARDIOMYOPATHY

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

&lt; 15 min.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

She was DNR.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

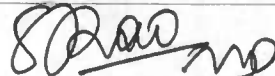
28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D-34525

29d. Date signed (Month, Day, Year)

April 4, 1997

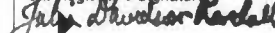
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.S. Rao, M.D. 4000 Mitchellville Road #220, Bowie, Maryland

31. Date filed (Month, Day, Year)

APR 07 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 1 Per PHY Film G746 4-29-97 rja

## Certificate of Death

Reg. No.

97 12884

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
|---|--|---|---|---|---|---|----|---------------------|--|----------------------------------|--|--|----|------------------------------|-----------------|----------------------------------|--|--|----|--|---|-----------------|----------------------------------|--|--|--|----|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JAMES ANDERSON, Sr.</b>  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>26</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>16:20</b>  |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SAINT AGNES HOSPITAL</b>   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |   | 4c. County of Death<br><b>n/a</b>                     |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 5. Social Security Number<br><b>216-32-5042</b>   | 6. Sex<br><input checked="" type="checkbox"/> Male <input type="checkbox"/> Female | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 22, 1937</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>SC</b> |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| Usual Residence of Decedent   |  |   |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>n/a</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 10e. Street and Number<br><b>36 N. Roseale St.</b>  |  | 10f. Zip Code<br><b>21229</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b> |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>  |   | 16b. Kind of Business/Industry<br><b>Wm Mason Company</b>   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Anderson, Sr.</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rebecca Cockley</b>   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Cecelia Anderson/wife</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>36 N. Roseale St. Baltimore, MD 21229</b> |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Western Star</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>James A. Morton &amp; Sons Funeral Home<br/>1701 Laurens St. Balto., MD 21217</b>  |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>e.</td> <td><b>Hyperkalemia</b></td> <td>Approximate Interval Between Onset and Death<br/><b>6 hours</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>f.</td> <td><b>Chronic Renal Failure</b></td> <td><b>10 years</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="2">g.</td> <td><b>Acquired Immunodeficiency Syndrome</b></td> <td><b>10 years</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> <td></td> </tr> <tr> <td colspan="2">h.</td> <td></td> <td></td> </tr> </table> |  |   |   |   |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. | <b>Hyperkalemia</b> | Approximate Interval Between Onset and Death<br><b>6 hours</b> | Due to (or as a consequence of): |  |  | f. | <b>Chronic Renal Failure</b> | <b>10 years</b> | Due to (or as a consequence of): |  |  | g. |  | <b>Acquired Immunodeficiency Syndrome</b> | <b>10 years</b> | Due to (or as a consequence of): |  |  |  | h. |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | e.   | <b>Hyperkalemia</b>   | Approximate Interval Between Onset and Death<br><b>6 hours</b>  |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
|   | Due to (or as a consequence of):   |   |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
|   | f.   | <b>Chronic Renal Failure</b>  | <b>10 years</b>   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
|   | Due to (or as a consequence of):   |   |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| g.  |  | <b>Acquired Immunodeficiency Syndrome</b>   | <b>10 years</b>   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| Due to (or as a consequence of):  |  |   |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| h.  |  |   |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation</b><br><b>Cerebrovascular Accident</b>   |  |   |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)<br><b>April 26, 1997</b>  |   | 28b. Time of Injury<br><b>M</b>   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
|   |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D38543</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 26, 1997</b>  |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>KEVIN H. SCRUBAS MD 900 Caton Avenue Baltimore Maryland 21229</b>  |  |   |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  | 32. Registrar's Signature<br>  |   |   |   |   |    |                     |  |                                  |  |  |    |                              |                 |                                  |  |  |    |  |   |                 |                                  |  |  |  |    |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12885

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HUDAM ABU-ALRUB</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 28, 1997</b>  |  | 3. Time of Death<br><b>6:50 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-47-3460</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>53</b> Yrs.   |  | 8. Date of Birth<br>Month Day Year<br><b>MAY 25, 1943</b>                            |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>IRBID, JORDAN</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>n/a</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>                                      |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1721 GLEN RIDGE ROAD</b>   |  | 10f. Zip Code<br><b>21235</b>  |  | 10g. Citizen of What Country?<br><b>JORDAN</b>                                       |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>-</b> College (1-4 or 5+) <b>4 YEARS</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SCHOOL TEACHER</b>  |  | 16b. Kind of Business/Industry<br><b>JORDAN</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>ABDULATIF MEREISH</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>AMMOUN FAURY</b>   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ISLAM ALRUB - SON</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1721 GLEN RIDGE RD., BALTIMORE, MD# 35</b>   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>   |  | Date<br><b>4-29-97</b>   |  | 20c. Location - City or Town, State<br><b>RANDALLSTOWN, MD</b>                       |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Bladys Wanner</b>   |  |   |  | 22. Name and Address of Facility<br><b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Gastric Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br><b>Paul Celano, M.D.</b>   |  | 29c. License number<br><b>D30929</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/28/97</b>  |  |  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAUL CELANO, MD 6567 N. Charles ST, BALTIMORE, MD 21204</b>  |  |   |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12886

ITEM#10e PER F.H. FLM#G746 4/29/97 J.A. Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>JESSE A. ARMSTRONG</b>  |  |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>18</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>7:20 PM</b>                         |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>740 POPLAR GROVE STREET</b>   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>n/a</b>                          |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-14-7925</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>06-10-24</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent  |  |   |  |  |  |  |  |
|  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  | 10e. Street and Number<br><b>940 POPLAR GROVE apt. 8s</b>  |  |   | 10f. Zip Code<br><b>21216</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>      |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 th</b> College (1-4 or 5+) <b>-</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>COUNSELOR</b>                  |  | 16b. Kind of Business/Industry<br><b>STATE of MARYLAND</b> |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>ROBERT ARMSTRONG</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>ELVIRA FAWCETT</b>   |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>IRMA THOMAS</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5506 WINSTON AVE., BALTIMORE, MD 21207</b> |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WOODLAWN CEMETERY</b>  |  | Date<br><b>4-24-97</b>   |  | 20c. Location - City or Town, State<br><b>BALTIMORE Co., MD</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>WM. C. MARCH FH.-4300 WABASH AVENUE</b>   |  |  |  |  |
|  | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |  |   |  |  |  | 24a. Was an autopsy performed?<br><b>inspection</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  |  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  |  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
|  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br>   |  |   | 29c. License number<br><b>O.C.M.E.</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 26, 1997</b>   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |  |   | 32. Registrar's Signature<br>                               |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



97 12887

DHHM 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

### To Be Completed by Funeral Director

**Medical Certification: To Be Completed by Physician/Medical Examiner**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12888.

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |                                |  |   |
|---|--|--|---|--|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Joseph Alexander Boston Sr.</i>   |  |   |  | 2. Date of Death<br>Month <i>04</i> Day <i>27</i> Year <i>97</i>   |                                | 3. Time of Death<br><i>0200</i>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>3817 Grantley Road</i>  |  |   |  | 4b. City, Town, or Location of Death<br><i>BALTIMORE</i>   |                                | 4c. County of Death<br><i>BALTIMORE CITY</i>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><i>218-14-1763</i>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>73</i> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><i>07 01 23</i>   | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i> |
|   | Usual Residence of Decedent  |  |   |  |  |                                |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><i>Maryland</i>  |  | 10b. County<br><i>N/A</i>   |  | 10c. City, Town or Location<br><i>Baltimore</i>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|   | 10e. Street and Number<br><i>3817 Grantley Road</i>  |  |   |  | 10f. Zip Code<br><i>21215</i>  |                                | 10g. Citizen of What Country?<br><i>U.S.A</i>  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br><i>WW II Army</i>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><i>Afro. American</i>            |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>6</i>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Educator</i>  |  | 16b. Kind of Business/Industry<br><i>Baltimore City</i>  |                                |  |   |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><i>Joseph Alexander Boston Sr.</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Susan Marie Moaney</i>   |                                |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Mrs. Carolyn Boston (Wife)</i>  |  |   |  | 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code)<br><i>3817 Grantley Rd, Baltimore Md. 21215</i>   |                                |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Garrison Forest La Cem</i>   |  | 20c. Location - City or Town, State<br><i>5/1/97 Owings Mills, Md</i>  |                                | 20d. Date  |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Joseph L. Russ</i>   |  | 22. Name and Address of Facility<br><i>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Baltimore, Md. 21216</i>  |  |  |                                |  |   |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |                                |  |   |
|   | Immediate Cause (Final disease or condition resulting in death)<br>a. <i>SQUAMOUS CELL CARCINOMA OF LUNG W/ BRAIN METS</i> 54 YRS  |  |   |  |  |                                |  |   |
|   | Due to (or as a consequence of):   |  |   |  |  |                                |  |   |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.                             |  |   |  |  |                                |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Adenocarcinoma of Prostate</i>  |  |   |  |  |                                |  |   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |                                |  |   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                |  |   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |                                |  |   |
| State Registrar   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                |  |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |                                |  |   |
|   | 29b. Signature and title of certifier<br><i>Noel E. McCally, MD</i>  |  | 29c. License number<br><i>D19607</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>04/28/97</i>   |                                |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>NOEL E. MCCALLY, MD, 3901 GREENSPRING AVE #104, BALTIMORE, MD. 21211</i> |  |  |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><i>APR 29 1997</i>   |  |  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |                                |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 12889

Reg. No.

|   |  |   |   |  |  |  |   |  |
|---|--|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARIE F. BOWEN</b>  |   |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>24</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>7:15 AM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-12-3441</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>April 1, 1922</b>             |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |   |  |  |  |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |   |   |  |  |  |   |  |
|   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>6811 Campfield Road</b>   |   |   |  | 10f. Zip Code<br><b>21207</b>  |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>                        |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John William Philip Hoffman</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha A. Stuckert</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sharon McLemore (Niece)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6414 Glenoak Avenue, Baltimore, Maryland 21214</b>                                       |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory 4/25/97</b>                                    |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home Inc.<br/>3331 Brehms Lane, Baltimore, Maryland 21213</b>   |  |   |  |
|   | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Cerebrovascular Accident</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c. <b>Artrial Fibrillation</b><br>Due to (or as a consequence of):<br>d. <b>Carcinomatosis</b> |   |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive heart failure, hypertension, aortic aneurism, depression</b>  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
|   |  |   |   |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Laura Payas, MD</b>   |   | 29c. License number<br><b>AS 2402321-LF9029</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 24, 1997</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>LAURA PAYAS, SINAI HOSPITAL, BALTIMORE, MD</b>   |  |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  | 32. Registrar's Signature<br>   |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12890

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Audrey L. Butler

2. Date of Death

Month Day Year  
APR. 24 1997

3. Time of Death

19:34 pm

4a. Facility Name (If not institution, give street and number)

NORTH WEST HOSPITAL

4b. City, Town, or Location of Death

N/A

4c. County of Death

BALTIMORE CO.

Funeral  
Director

5. Social Security Number

218-42-0685

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV. 18 1931

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14 Pine Run Court

10f. Zip Code

21244

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th grade

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Diet Tech.

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

George W. Crawford

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Hall-Crawford

19a. Informant's Name/Relationship (Type, Print)

Stephanie Butler-Sebree/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Pine Run Court, Randallstown, Maryland 21244

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VETERANS 4-30

Date

20c. Location - City or Town, State

OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee

▶ *Harri P. Chow*

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H  
1206 W. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. *Cervical Cancer*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *Donald Brown MD*

29c. License number

D 36753

29d. Date signed (Month, Day, Year)

4/28/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

4120 Patterson Ave Baltimore MD 21215

31. Date filed (Month, Day, Year)

APR. 29 1997

32. Registrar's Signature

*Julia Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12891

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES ANTHONY BYRD

2. Date of Death

APRIL 24, 1997

3. Time of Death

8:27 PM.

4a. Facility Name (If not institution, give street and number)

3828 WEST FOREST PARK AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-66-5446

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 25 1957

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

370 W. FOREST PARK AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th grade

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing Assistant

16b. Kind of Business/Industry

Health

17. Father's Name (First, Middle, Last)

John A. Byrd

18. Mother's Name (First, Middle, Maiden Surname)

Mary M. Byrd

19. Informant's Name/Relationship (Type, Print)

Angela Byrd/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3618 Bowers Avenue Apt D, Baltimore Maryland 21207

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

4-28-97 BALTIMORE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H  
1206 W. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot wound to head

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?  
☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify)

AT

SCENE

27. Manner of Death

☐ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☒ Homicide

28a. Date of Injury (Month, Day Year)

4-24-97

28b. Time of Injury

2:23 PM

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3828 West Forest Park Av.

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

APRIL 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Johanna Davidson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12892

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline

Backhaus

2. Date of Death  
Month Day Year  
APRIL 25 1997

3. Time of Death  
8:55 am

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

216-36-3944

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 11, 1936

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1514 E. Clement Street

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th Grade

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Daniel Herring

18. Mother's Name (First, Middle, Maiden Surname)

Martha Reed

19a. Informant's Name/Relationship (Type, Print)

Norman N. Backhaus / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1514 E. Clement Street, Baltimore MD 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville VA Cemetery

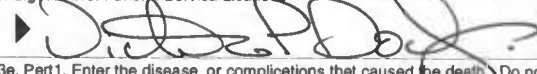
Date

April 29, 1997

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.  
1501 E. Fort Avenue Baltimore Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. subarachnoid hemorrhage

Due to (or as a consequence of):

b. cerebral aneurysm

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

96 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

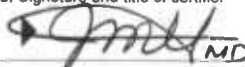
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

 MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

April 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jean-Max Hegerth, MD 600 N. Wolfe St. Baltimore, MD 21287

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature



State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

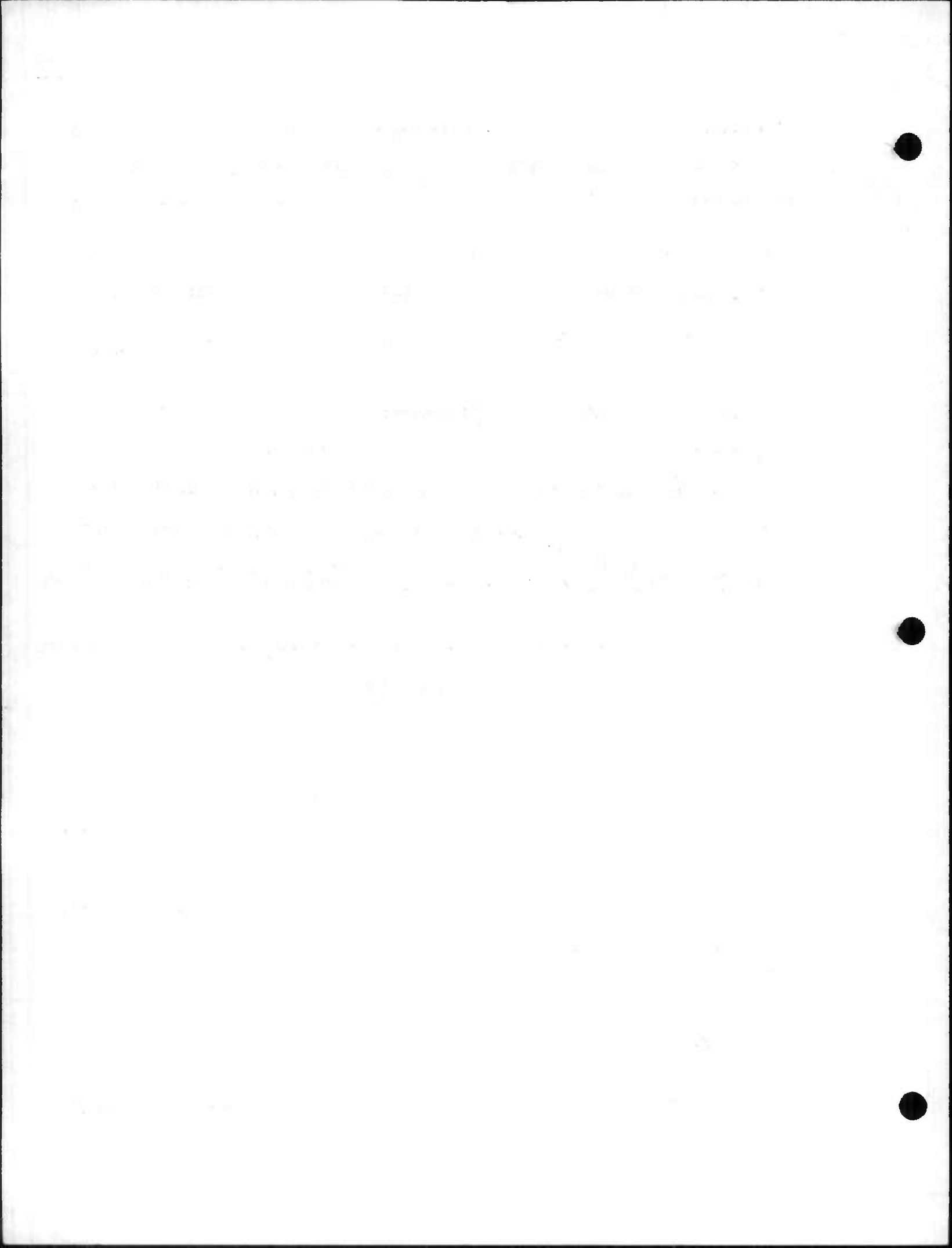
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

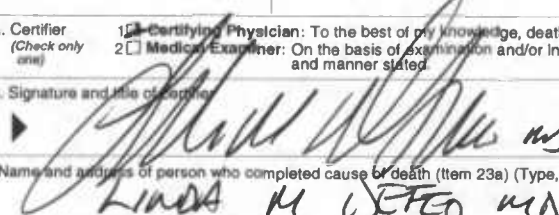

State of Maryland / Department of Health and Mental Hygiene

97 12893

Item 7 per FH Film G747 5-5-97 rja

## Certificate of Death

Reg. No.

|  |   |  |  |                                |  |  |  |   |                                   |
|--|---|--|--|--------------------------------|--|--|--|---|-----------------------------------|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>BERTHA A. BOHLE</b>  |  |  |                                | 2. Date of Death<br>Month <b>APRIL</b> Day <b>27</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>2:15 PM</b>   |   |                                   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b>   |  |  |                                | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |   |                                   |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-18-4355</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>September 9, 1922</b>                                |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |                                   |
|  | Usual Residence of Decedent   |  |  |                                |  |  |  |   |                                   |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>Baltimore City</b>   |                                |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |                                   |
|  | 10e. Street and Number<br><b>811 E. Fort Avenue</b>   |  |  | 10f. Zip Code<br><b>21230</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |                                   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |                                   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th Grade</b> College (1-4 or 5+) <b>N/A</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |                                | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |   |                                   |
|  | 17. Father's Name (First, Middle, Last)<br><b>frank Smith</b>   |  |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna E. Howard</b>   |  |  |   |                                   |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>John T. Bohle / Husband</b>  |  |  |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>811 E. Fort Avenue, Baltimore Maryland 21230</b>   |  |  |   |                                   |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>   |                                | Date<br><b>May 1, 1997</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore City</b>   |   |                                   |
|  | 21. Signature of Funeral Service Licensee<br>   |  |  |                                | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home, Inc.<br/>1501 E. Fort Avenue, Baltimore Maryland 21230</b>   |  |  |   |                                   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.<br><b>MYOCARDIAL INFARCTION</b>   |  |  |                                |  |  |  |   |                                   |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PULMONARY EDEMA</b>   |  |  |                                |  |  |  |   |                                   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23a. Immediate Cause (Final disease or condition resulting in death)<br><b>MYOCARDIAL INFARCTION</b>  |  | Due to (or as a consequence of):<br><b>ASCVD</b>   |                                | Approximate Interval Between Onset and Death<br><b>MINUTES</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |                                   |
|  | 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | Due to (or as a consequence of):   |                                | 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                   |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |  |   |                                   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |                                | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |                                | 29c. License number<br><b>D33010</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 27, 1997</b>   |   |                                   |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LINDA M. WEFEL MD</b>  |  |  |                                | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |  |  |   |                                   |
|  | 32. Registrar's Signature<br>  |  |  |                                | 33. Harbor Hospital Center   |  |  |   |                                   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

5





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12894

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES T. BRIDGEFORTH SR.

2. Date of Death

APRIL 27

Day

Year

3. Time of Death

10:35 AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

230-34-3482

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 7, 1922

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

2805 W. LANVALE STREET

10f. Zip Code

21216

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 Never Married 2 X Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

X Yes 2 No  
If Yes, Give Year or Dates: 10-43  
03-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

BETHLEHEM STEEL Co.

17. Father's Name (First, Middle, Last)

JAMES ARTHUR BRIDGEFORTH

18. Mother's Name (First, Middle, Maiden Surname)

ELVETIA FIELDS

19a. Informant's Name/Relationship (Type, Print)

ROSA LEE BRIDGEFORTH-wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2805 W. LANVALE ST., BALTIMORE, MD #16

20a. Method of Disposition

X Burial 2 Cramation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VA CEM. 5-2-97 OWINGS MILLS, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Mladys W. W. W.

22. Name and Address of Facility

WM. C. MARCH FH.-4300 WABASH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ASTHMA

YEARS

Due to (or as a consequence of):

c. DECUBITUS ULCERS

MONTHS

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AS ABOVE

23b. Did tobacco use contribute to the cause of death?

1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 X Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 X No

Hospital:

1 X Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 X Natural 5 Pending Investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 X Yes 2 No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Certifying Physician

2 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. Janeddi, M.D.

29c. License number

D 47014

29d. Date signed (Month, Day, Year)

APRIL 27, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNS HOPKINS HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12895

|   |  |   |  |  |   |   |   |  |
|---|--|---|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Alma S. Bitz</b>                          |   |  |  | 2. Date of Death<br>Month Day Year<br><b>April 27, 1997</b> |   | 3. Time of Death<br><b>9:55 PM</b>                        |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>20100 York Road</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Parkton</b>      |   | 4c. County of Death<br><b>Baltimore</b>                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-05-9806</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br><b>Feb 2, 1913</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                              |   |  |  |   |   |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Pikesville</b>   |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br><b>7019 Plymouth Road</b>   |  |   |  | 10f. Zip Code<br><b>21208</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12 Years</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Spencer</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maude Potter</b>   |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. William S. Bitz, Jr.</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20100 York Road Parkton, Maryland 21120</b>  |   |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |  | Date<br><b>4/30</b>  |   | 20c. Location - City or Town, State<br><b>Woodlawn, Maryland</b>                            |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Stephen M Jenkins</i>   |  |   |  | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, MD 21133</b>   |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metastatic Colon Cancer</b><br>Due to (or as a consequence of):<br><br>b. _____ Due to (or as a consequence of):<br><br>c. _____ Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Home <input type="checkbox"/> Other (Specify)   |  |   |  |  |   |   |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |   |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |   |   |  |
| 29b. Signature and title of certifier<br><i>Cheryl Garbar</i>   |  |   |  | 29c. License number<br><b>H-60867</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4-29-97</b>                                       |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Cheryl Garbar PO 21 Cross Roads Drive Suite 415 Owings Mills, MD 21117</b>   |  |   |  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  |   |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>  |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12896

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEFINA BARRIENTOS

2. Date of Death

Month Day Year  
APRIL 27, 1997

3. Time of Death

11:35 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

214-04-8836

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 6, 1920

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Woodstock

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

12 Deep Powder Court

10f. Zip Code

21163

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Asian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (14 or 5+)

2 Years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Cesario Saavedra

18. Mother's Name (First, Middle, Maiden Surname)

Francisca Loculan

19a. Informant's Name/Relationship (Type, Print)

Mrs. Emerlinda Meneses

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Deep Powder Court Woodstock, MD 21163

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Cemetery

Date

5/1

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Stephen M. Jenkins

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Ruptured Aortic Aneurysm

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10 Hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STATUS POST AORTIC ARCH GRAFT  
AND AORTIC VALVE PROSTHESES

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicidal ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORLANDO B. CONNAN MD

NORTHWEST HOSPITAL CENTER  
RANDALLSTOWN, MD. 21133State  
Registrar

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 16b, per F.H. G-746 4/29/97 reb

Certificate of Death

Reg. No. 97 12897

|                                     |   |  |  |  |   |  |
|-------------------------------------|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MACK</b>   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>19</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>11:20 P.M</b>  |  |
|                                     | 4e. Facility Name (If not institution, give street and number)<br><b>SHOCK TRAUMA CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>217-62-9098</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.  |  |
|                                     | 8. Date of Birth (Month, Day, Year)<br><b>August 14, 1954</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |  |   |  |
| To Be Completed by Funeral Director | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
|                                     | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>2821 Greenlawn Road</b>   |  | 10f. Zip Code<br><b>21207</b>   |  |
|                                     | 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>Collage (1-4 or 5+) <b>Collage</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Welder</b>   |  | 16b. Kind of Business/Industry<br><b>DERBY STEEL CO. Unknown</b>  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Clyde Burrell Sr.</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Wyoming Griffith</b>   |  |   |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jacqueline McDonald</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>308 McDonald Road, Glen Burnie, Maryland 21060</b>                         |  |   |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>4-26-97 Woodlawn, Maryland</b>  |  |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Joseph H. Brown Jr. Funeral Home, PA<br/>2146 N. Fulton Avenue, Baltimore, Maryland 21217</b>   |  | Approximate Interval Between Onset and Death  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. BLUNT FORCE INJURIES TO HEAD</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |  |  |  |   |  |

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |

|  |  |  |  |
|--|--|--|--|
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>4 19 97</b>   |  |
| 28b. Time of Injury<br><b>2245 PM</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred<br><b>SHOOT WDS BLOWN.</b>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>200 BLK EUTAW ST BALTIMORE MD</b>   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |  |
| 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 20, 1997</b>   |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>MARY ANN P. KONOWICK 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |  | 32. Registrar's Signature<br>  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### Certificate of Death

Reg. No.

97 12898

| Physician /Medical Examiner   |  |   |                                |   |                  | 2. Date of Death<br>Month Day Year   |  | 3. Time of Death                         |  |   |  |
|---|--|---|--------------------------------|---|------------------|--|--|--|--|---|--|
| HERMAN JOURDAN BUSH, JR.  |  |   |                                |   |                  | APRIL 25 1997  |  | 12:47 PM                                 |  |   |  |
| 4a. Facility Name (If not institution, give street and number)  |  |   |                                |   |                  | 4b. City, Town, or Location of Death   |  | 4c. County of Death                      |  |   |  |
| MARYLAND GENERAL HOSPITAL   |  |   |                                |   |                  | BALTIMORE  |  | N/A                                      |  |   |  |
| 5. Social Security Number   |  | 6. Sex  | 7. Age (In yrs. last birthday) | If Under 1 Year   | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)  |  | 9. Birthplace (State or Foreign Country) |  |   |  |
| 262-50-0268   |  | 1 M 2 F   | 61 Yrs.                        | Months Days   | Hours Min.       | Apr. 23, 1936  |  | Georgia                                  |  |   |  |
| Usual Residence of Decedent   |  |   |                                |   |                  |  |  |  |  |   |  |
| 10a. State  |  | 10b. County   |                                | 10c. City, Town or Location   |                  | 10d. Inside City Limits  |  |  |  |   |  |
| Maryland  |  | N/A   |                                | Baltimore   |                  | 1 Yes 2 No   |  |  |  |   |  |
| 10e. Street and Number  |  |   |                                |   |                  | 10f. Zip Code  |  | 10g. Citizen of What Country?            |  |   |  |
| 905 Pennsylvania Ave #2A  |  |   |                                |   |                  | 21201  |  | USA                                      |  |   |  |
| 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yaa or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |                  | 14. Race - American Indian, Black, White, etc.                               |  |  |  |   |  |
| 1 Naver Married 2 Married 3 Widowed 4 Divorced  |  | 1 Yes 2 No  |                                | 1 Yes 2 No Specify:   |                  | Specify: Black   |  |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)   |  |   |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)     |                  | 16b. Kind of Business/Industry   |  |  |  |   |  |
| Elementary/Secondary (0-12) College (1-4 or 5+)   |  |   |                                | Truck Driver  |                  | Ryder Trucking Co  |  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)   |  |   |                                |   |                  | 18. Mother's Name (First, Middle, Maiden Sumame)                             |  |  |  |   |  |
| HERMAN J. BUSH, SR  |  |   |                                |   |                  | Minnie Mosley  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)  |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)                 |                  |  |  |  |  |   |  |
| Jodel Bush /wife  |  |   |                                | 905 PENNSYLVANIA AVE #2A BALTIMORE, Maryland 21201  |                  |  |  |  |  |   |  |
| 20a. Method of Disposition  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)                          |                                | Date  |                  | 20c. Location - City or Town, State  |  |  |  |   |  |
| 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  |  | KING MEMORIAL PARK  |                                | 5/3/97  |                  | Randallstown, Md   |  |  |  |   |  |
| 21. Signature of Funeral Service Licensee   |  |   |                                | 22. Name and Address of Facility  |                  |  |  |  |  |   |  |
| Guy Harris  |  |   |                                | CHATHAM - HARRIS F.H. 5240 REISTERSTOWN ROAD BALTIMORE, Maryland 21215  |                  |  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |   |                                |   |                  |  |  |  |  | Approximate Interval Between Onset and Death                                |  |
| Immediata Cause (Final disease or condition resulting in death)   |  |   |                                |   |                  |  |  |  |  |   |  |
| a. Arteriosclerotic Cardiovascular Disease  |  |   |                                |   |                  |  |  |  |  |   |  |
| Due to (or as a consequence of):  |  |   |                                |   |                  |  |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |                                |   |                  |  |  |  |  |   |  |
| b. Due to (or as a consequence of):   |  |   |                                |   |                  |  |  |  |  |   |  |
| c. Due to (or as a consequence of):   |  |   |                                |   |                  |  |  |  |  |   |  |
| d. Due to (or as a consequence of):   |  |   |                                |   |                  |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |   |                  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?                      |  |
|   |  |   |                                |   |                  |  |  |  |  | 1 Yes 2 No 3 Probably 4 Unknown   |  |
|   |  |   |                                |   |                  |  |  |  |  | 24a. Was an autopsy performed?  |  |
|   |  |   |                                |   |                  |  |  |  |  | 1 Yes 2 No  |  |
|   |  |   |                                |   |                  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death? |  |
|   |  |   |                                |   |                  |  |  |  |  | 1 Yes 2 No  |  |
| 25. Was case referred to medical examiner?  |  | 26. Place of Death (Check only one)   |                                |   |                  |  |  |  |  |   |  |
| 1 Yes 2 No  |  | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) |                                |   |                  |  |  |  |  |   |  |
| 27. Manner of Death   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury   |                  | 28c. Injury at Work?   |  | 28d. Describe how injury occurred        |  |   |  |
| 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined   |  |   |                                | M   |                  | 1 Yes 2 No   |  |  |  |   |  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)          |                                |   |                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |   |  |
| 29a. Certifier (Check only one)   |  |   |                                |   |                  |  |  |  |  | 29c. License number   |  |
| 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |   |                  |  |  |  |  | O.C.M.E.  |  |
| 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                            |  |   |                                |   |                  |  |  |  |  | 29d. Date signed (Month, Day, Year)   |  |
| 29b. Signature and title of certifier   |  |   |                                |   |                  |  |  |  |  | APRIL 26, 1997  |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)  |  |   |                                |   |                  |  |  |  |  |   |  |
| J.LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201  |  |   |                                |   |                  |  |  |  |  |   |  |
| 31. Data filed (Month, Day, Year)   |  |   |                                |   |                  |  |  |  |  | 32. Registrar's Signature   |  |
| APR 29 1997   |  |   |                                |   |                  |  |  |  |  | John Davidson-Randall   |  |

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar



|   |   |  |   |   |  |  |   |   |  |
|---|---|--|---|---|--|--|---|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH BAIN</b>  |  |   |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>23</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>5:25 PM</b>                                      |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>BON SECOUR HOSPITAL</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>                                       |   |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>218-58-4887</b>   |  | 6. Sex<br><b>20 M</b>   |   | 7. Age (In yrs. last birthday)<br>Yrs. <b>20</b>   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 29, 1952</b>            |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>                         |   |  |
| <b>To Be Completed by Funeral Director</b>  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>  |  | 10e. Street and Number<br><b>1507 W. FAIRMOUNT AVENUE</b>   |   | 10f. Zip Code<br><b>21223</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |   |  |
|   | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b>                        |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: Black</b> |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>11th grade</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b> |   | 16b. Kind of Business/Industry<br><b>PRIVATE BUSINESS</b>  |  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>CLEVELAND GRAY</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SHIRLEY BAIN</b>   |  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>BELENDIA HURRIE / Sister</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13 LAMOLLY OAKS Way #5 BALTIMORE, Maryland 21228</b> |  |   |   |  |
|   | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JOSEPH H. MEMORIAL BARRONS</b>                 |   | 20c. Location - City or Town, State<br><b>DUNDALK, Maryland</b>  |  | 20d. Date<br><b>4/29/97</b>   |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |   | 22. Name and Address of Facility<br><b>CHATHAM HARRIS Funeral Home 5040 REISTERSTOWN ROAD BALTIMORE, Maryland 21215</b>                                  |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |  |  |   |   |  |
|   | <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </div> <div style="width: 60%;">                 a. <b>ACUTE NARCOTIC INTOXICATION</b><br/>Due to (or as a consequence of):<br/><br/>                 b. Due to (or as a consequence of):<br/><br/>                 c. Due to (or as a consequence of):<br/><br/>                 d. Due to (or as a consequence of):             </div> <div style="width: 10%; text-align: center;">                 Approximate Interval Between Onset and Death             </div> </div> |  |   |   |  |  |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>  |   |  |   |   |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |   |  |   |   |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>  |   |  |   |   |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |   |  |   |   |  |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>  |   |  |   |   |  |  |   |   |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |   | 28a. Date of Injury<br><b>Month Day Year</b><br><b>FOUND 4-23-97</b> |   | 28b. Time of Injury<br><b>FOUND 4:50 PM</b>   |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>                    |   | 28d. Describe how injury occurred<br><b>UNKNOWN</b> |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND IN HOUSE</b>   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1202 W. FAYETTE STREET BALTIMORE, MARYLAND</b> |  |  |   |   |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |   |  |   |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  |   | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 24, 1997</b> |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |   |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |   |  |   |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



97 12900

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SHURA BLOOM</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>APRIL</b> DAY <b>21</b> YEAR <b>1997</b>   |  | 3. TIME OF DEATH<br><b>10:50 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>263-42-8863</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 28, 1920</b>                          |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hebrew Home Of Greater Washington</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>                                      |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>6105 Montrose Road</b>  |  |  |  | 10f. ZIP CODE<br><b>20852</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11 Years</b><br>College (1-4 or 5+) <b>Housewife</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Morris Mallin</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Clara Kushner</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sonny Bloom</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2412 Henslowe Drive, Potomac, Maryland 20854</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Baron Hirsch Cemetery 4/25/1997</b>  |  | 20c. LOCATION — City or Town, State<br><b>Montreal, Quebec Canada</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald C. Stettin</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br/>232 CARROLL STREET, N.W.<br/>WASHINGTON, D.C. 20012-2095</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ANGRENE BOTH LOWER LEGS.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>ANGRENE BOTH LOWER LEGS.</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death <b>2 WEEKS</b> |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>STROKE</b>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>P. Talwar, M.D.</b>  |  | 29c. LICENSE NUMBER<br><b>D 36552</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APRIL 22 1997</b>                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>P. TALWAR, 6121 MONTROSE ROAD, ROCKVILLE MD. 20852</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 29 1997</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12901

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CARRIE CUNNINGHAM

2. Date of Death

Month Day Year  
APRIL 25 1997

3. Time of Death

11:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

214-16-8550

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 26, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lochearn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3706 Sylvan Drive

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12 yearsCollege (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Family &amp; Childrens Soc.

17. Father's Name (First, Middle, Last)

Wilbur W. Whittington

18. Mother's Name (First, Middle, Maiden Surname)

May Irene Unknown

19a. Informant's Name/Relationship (Type, Print)

Edward C. Mackie (Attorney)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401 N. Charles St. Baltimore, MD 21201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Woodlawn Cemetery

Date

4-29-97

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

John K. Ayne

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.  
8728 Liberty Road Randallstown, MD 2113323a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. RESPIRATORY FAILURE

Due to (or as a consequence of):

2 DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS

Due to (or as a consequence of):

c. RESTRICTIVE VENTILATORY DEFECT 4 DAYS

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K.S. Rao M.D.

29c. License number

D43462

29d. Date signed (Month, Day, Year)

APRIL 25 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K.S. Rao M.D.  
NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, M.D.State  
Registrar

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

John K. Ayne

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Health or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12902

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD CROSS

2. Date of Death

Month Day Year  
4-25-97

3. Time of Death

9:19 a.m.

4a. Facility Name (If not institution, give street and number)

539 N LUZERNE AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

215-30-1232

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08-10-35

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

539 N. Luzerene Avenue

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

☐ Navar Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6th GradeCollege (1-4or 5+)  
NA16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

various trades

17. Father's Name (First, Middle, Last)

Harvey Cross, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Carter

19a. Informant's Name/Relationship (Type, Print)

Annette Peoples

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213  
1825 Rutland Avenue Baltimore, Maryland

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Voshell Mem. Gardens 04-30-97 Dundalk, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Baltimore, Maryland 21202  
WM.C. March FH 1101 E. North Avenue23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?INSPECTION  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

APRIL 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



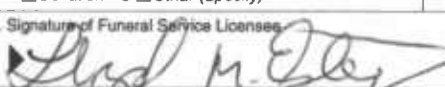

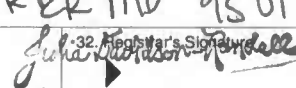
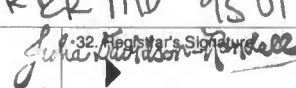
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12903

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LOUIS A. CLARK Sr.</b>  |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>26</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>105AM</b>   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>HOWARD COUNTY HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE/COLUMB</b>  |  | 4c. County of Death<br><b>HOWARD CO.</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>352-10-4555</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>12/01/1904</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MISS.</b>   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>HOWARD</b>   |  | 10c. City, Town or Location<br><b>COLUMBIA</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>5505 LUCYPENNY PLACE</b>   |  | 10f. Zip Code<br><b>21045</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>AFRO.AMERICAN</b>  |  |
| To Be Completed by Physician/Medical Examiner  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>Collega (1-4or 5+)</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PRESSER</b>                       |  | 16b. Kind of Business/Industry<br><b>DRY CLEANERS</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>HENRY CLARK</b>  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>AMANDA CLARK</b>   |  | 19a. Intendant's Name/Relationship (Type, Print)<br><b>GLADYS CLARK WIFE</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5505 LUCYPENNY PLACE, COLUMBIA, MARYLAND 21045</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                        |  |
| To Be Completed by Physician/Medical Examiner  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>5/2/97</b>  |  | 20c. Location - City or Town, State<br><b>CHICAGO, ILLINOIS</b>   |  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>ESTEP BROTHERS FUNERAL HOME, P.A.<br/>1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217</b>   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>CEREBRAL ANOXIA</b><br>Due to (or as a consequence of):<br><b>CARDIAL ARREST</b><br>Due to (or as a consequence of):<br><b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>ACUTE RENAL FAILURE</b><br><b>CONGESTIVE HEART FAILURE</b> |  | Approximate interval Between Onset and Death<br><b>5 DAYS</b><br><b>5 DAYS</b><br><b>10 YEARS</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |
|  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred  |  |
| To Be Completed by Physician/Medical Examiner  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28b. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of Certifier<br>   |  |
|  | 29c. License number<br><b>D 29909</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 26, 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SCOTT MAURER MD 9501 OLD ANNAPOLIS RD FELLICOTT CITY MD 21042</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |  |
| 32. Registrar's Signature<br> |  | 33. Registrar's Signature<br> |   | 34. Registrar's Signature<br> |  | 35. Registrar's Signature<br> |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 12904

## Certificate of Death

Reg. No.

|  |   |                           |   |  |   |  |  |   |  |  |
|--|---|---------------------------|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Edna H. Carney</b>   |                           |   |  | 2. Date of Death<br>Month Day Year<br><b>April 27, 1997</b>   |  | 3. Time of Death<br><b>9:45 AM</b>   |   |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>2642 St. Benedict Street</b>   |                           |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-03-3488</b>   |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>FEB 19, 1921</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |  |
|  | Usual Residence of Decedent   |                           |   |  |   |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>N/A</b> | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |  |
|  | 10e. Street and Number<br><b>2642 St. Benedict Street</b>   |                           |   |  | 10f. Zip Code<br><b>21223</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                           | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>William J. Chadwick</b>   |                           |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth S. White</b>  |  |  |   |  |  |
|  | 19a. Intomant's Name/Relationship (Type, Print)<br><b>Susan E. Mathews/Daughter</b>   |                           |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15208 Boundary Rd. New Freedom, PA 17349</b>  |  |  |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | Date<br><b>4/28/97</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |   |  |  |
|  | 21. Signature of Funeral Service Licenses<br><b>Edward A. Gregorchik</b>  |                           | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>  |  |   |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |                           |   |  |   |  |  |   | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br><b>SEIZURE DISORDER</b>  |   |                           |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |
|  |   |                           |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                           | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide   |   |                           | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
|  |   |                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                           |   |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Thomas S. Miller</b>   |   |                           |   |  | 29c. License number<br><b>D30272</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 28 1998</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THOMAS S. MILLER 700 WASHINGTON BLVD BALTO MD 21230</b>   |   |                           |   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |   |                           | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12905

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth M. Cropf

2. Date of Death  
Month Day Year

April 26, 1997

3. Time of Death

1:20 PM

4a. Facility Name (If not institution, give street and number)

315 Ferndale Road

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

503-48-2843

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

OCT 7, 1920

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

315 Ferndale Road

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Office Administrator

16b. Kind of Business/Industry

Federal  
Government

17. Father's Name (First, Middle, Last)

Frank Miller

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Poorbaugh

19a. Informant's Name/Relationship (Type, Print)

Bruce E. Cropf, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1702 Abelia Rd. Fallston, MD 21047

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc. 4/28/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Lymphoma

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

5 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Leukemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

James E. Gardner MD

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

April 28 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St Baltimore MD 21231

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12906

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><i>Ellie Collins</i>   |  |   |  | 2. Date of Death<br>Month <i>4</i> Day <i>25</i> Year <i>97</i>  |  | 3. Time of Death<br><i>3:42 PM</i>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Johns Hopkins Bayview Medical Center</i>  |  |   |  | 4b. City, Town, or Location of Death<br><i>Baltimore, MD</i>   |  | 4c. County of Death<br><i>city</i>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><i>215-05-4834</i>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>96</i> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><i>April 23, 1901</i>                     |  |
|   | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>  |  | 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Baltimore</i>  |  | 10c. City, Town or Location<br><i>Edgemere</i>                                   |  |
| To Be Completed by Funeral Director           | Usual Residence of Decedent  |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><i>6809 North Point Road</i>                           |  |
|   | 10f. Zip Code<br><i>21219</i>  |  |   |  | 10g. Citizen of What Country?<br><i>United States</i>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>          |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8 Years</i><br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Housewife</i>   |  | 16b. Kind of Business/Industry<br><i>Own Home</i>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><i>Daniel E. Smith</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mary E. Rittler</i>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Brenda Wilson/Granddaughter</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>6809 North Pt. Road Edgemere, Maryland 21219</i>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Holly Hill Mem. Gdns.</i>  |  | Date<br><i>4/28/1997</i>   |  | 20c. Location - City or Town, State<br><i>Middle River, MD</i>                   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><i>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</i>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>sepsis</i><br>Due to (or as a consequence of):<br><i>intraabdominal infection</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><i>6 weeks</i> |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><i>12 hours</i>  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  | 29b. Signature and title of certifier<br>  |
|   | 29c. License number<br><i>96117</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>4/25/97</i>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>John TenBroek MD 4440 Eastern Ave. Baltimore MD 21224</i>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><i>APR 29 1997</i>  |  |   |  |  |  |  | 32. Registrar's Signature<br>  |
|   | State Registrar  |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12907

|   |   |   |  |  |  |  |   |   |  |
|---|---|---|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ina Elizabeth Carnes</b>                             |   |  |  | 2. Date of Death<br>Month Day Year<br><b>April 26 1997</b> |  | 3. Time of Death<br><b>12:10 P.M.</b>                   |   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>1827 Susquehanna Hall Road</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Whiteford</b>   |  | 4c. County of Death<br><b>Harford</b>                   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-14-1674</b>   |   | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.           |  | 6. Date of Birth (Month, Day, Year)<br><b>9-20-1912</b> |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>W. Va.</b>   |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>n/a</b>                                  |  | 10c. City, Town or Location<br><b>Baltimore</b>         |   |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3726 E. Lombard Street</b>  |  | 10f. Zip Code<br><b>21224</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b><br>College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Aircraft Worker</b>   |  | 16b. Kind of Business/Industry<br><b>Martins</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Charles Smith</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Oma Broyles</b> |  |
| 19a. Informant's Name/Relationship (Type, Print) <b>son</b><br><b>Mr. Michael J. Griffith</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1827 Susquehanna Hall Rd. Harford Co. Md. 21160</b>   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oaklawn Cemetery</b>  |   | 20c. Date<br><b>4/29/97</b>   |  |
| 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |   | 21. Signature of Funeral Service Licensee<br><i>Maria J. Zannino</i>  |  | 22. Name and Address of Facility<br><b>Joseph N. Zannino Jr. Funeral Hm.<br/>263 S. Conkling St. Baltimore, Maryland 21224</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Lung CA</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |   | Approximate Interval Between Onset and Death<br><b>3-4 months</b>       |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>C.O.P.D.</b><br><b>Coronary Artery Disease</b>   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Melvin Welinsky</i>   |  | 29c. License number<br><b>D-27921</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/28/97</b>  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>3411 Bank St. Melvin Welinsky</b>  |   | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 12908

Reg. No.

|   |  |   |   |  |  |  |  |  |
|---|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Margaret Clifton</i>                              |   |   |  | 2. Date of Death<br>Month: <i>April</i> Day: <i>23</i> Year: <i>1997</i>   |  | 3. Time of Death<br><i>3:42 am</i>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Union Memorial Hospital</i> |   |   |  | 4b. City, Town, or Location of Death<br><i>Baltimore City</i>  |  | 4c. County of Death<br><i>N/A</i>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>219 10 8483</i>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>71</i> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><i>July 1, 1925</i>                                     | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>  |
|   | Usual Residence of Decedent  |   |   |  |  |  |  |  |
| 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Baltimore</i>   |   | 10c. City, Town or Location<br><i>Baltimore</i>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><i>715 Maiden Choice Lane CR 214</i>  |  |   |   | 10f. Zip Code<br><i>21228</i>  |  | 10g. Citizen of What Country?<br><i>U.S.</i>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Home Maker</i>                         |  |  | 16b. Kind of Business/Industry<br><i>Own Home</i>  |  |
| 17. Father's Name (First, Middle, Last)<br><i>John M. Ripken</i>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Margaret B. McGraw</i>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Cody J. Clifton / Husband</i>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>715 Maiden Choice Lane CR214 Balto., Md. 21228</i> |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Md. State Veteran Cem.</i>  |  | Date<br><i>4/25/97</i>   |  | 20c. Location - City or Town, State<br><i>Crownsville, Maryland</i>  |
| 21. Signature of Funeral Service Licensee<br><i>Dana M. Zimrowski</i>   |  |   |   | 22. Name and Address of Facility<br><i>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</i>                                       |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) a. <i>Renal Failure</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last { b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   |  |  |  |  | Approximate Interval Between Onset and Death<br><i>one year</i>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Mohammed Salem M.D.</i>   |  |   |   | 29c. License number<br><i>ATZ 43846</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>April 23, 1997</i>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Mohammed Salem MD 201 E. University Pkwy BALTO md</i>  |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 29 1997</i>   |  |   |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

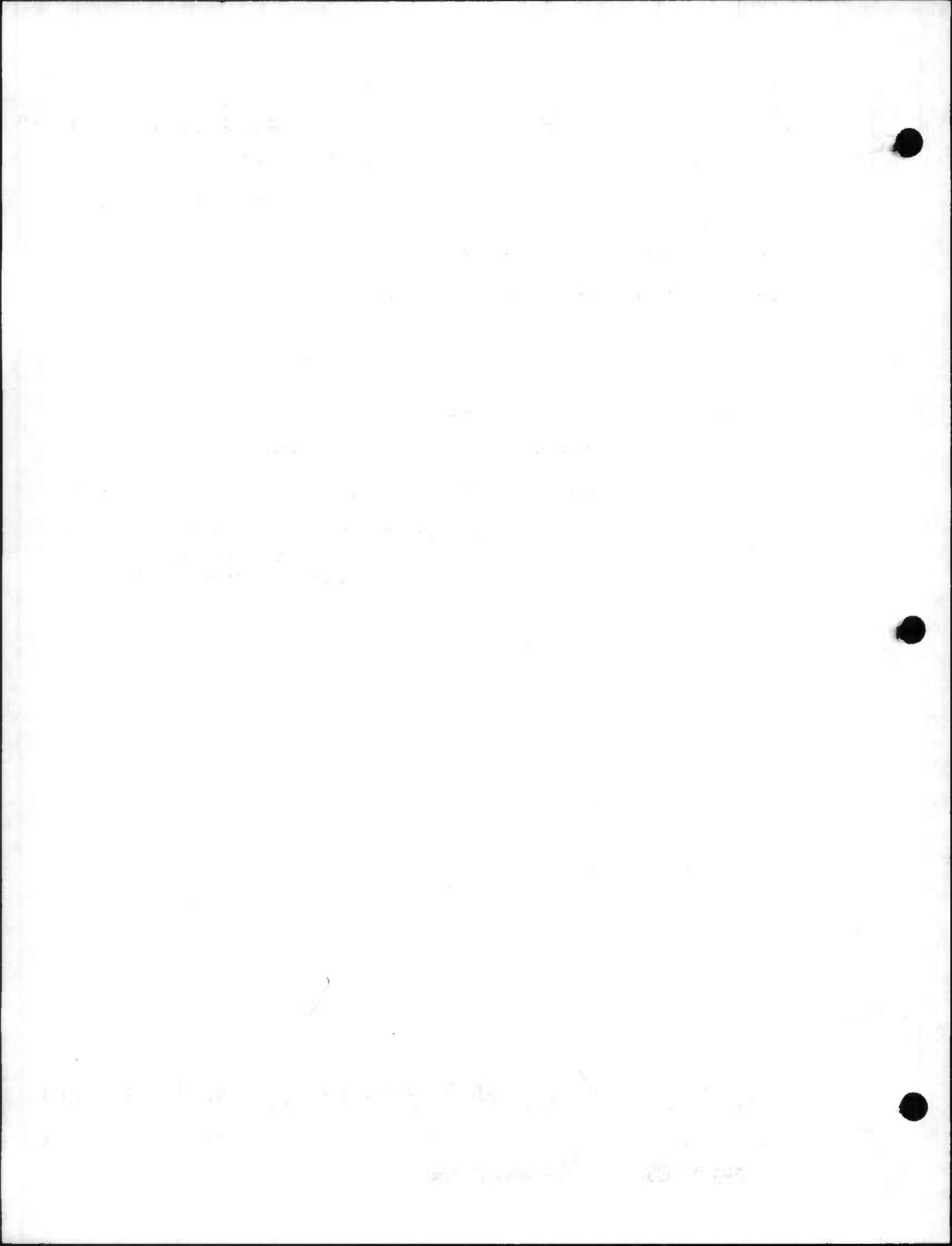
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 12909

Items: 23a part I, 27, 28a-f per MEO G-750 8/11/97 dh

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|---|----|---|--|--|--|--|--|----|----------------------------------|--|--|--|--|--|----|----------------------------------|--|--|--|--|--|----|----------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LINDA DICKEY</b>  |  |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>23</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>6:38 AM</b>   |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>   |   | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-64-3641</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>43</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>JUL 13, 1953</b>                                     |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | 10e. Street and Number<br><b>1433 Locust St.</b>   |  |   |  | 10f. Zip Code<br><b>21226</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cashier</b>                       |  | 16b. Kind of Business/Industry<br><b>Grocery</b>   |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Donald Gerald Devilbiss</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jesseline Ida Yingling</b>   |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Cheryl Watkins - daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6510 S. Charter Rd., Apt. B, Glen Burnie, Md. 21061</b>                                  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Pk.</b>   |  | 20c. Location - City or Town, State<br><b>Elkridge, Md.</b>  |   | 20d. Date<br><b>4/30/97</b>  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home at Meadowridge<br/>7250 Washington Blvd., Elkridge, Md. 21227</b>  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td colspan="6"> <b>PENETRATING LACERATION OF THE LEFT CHEST</b><br/>           Due to (or as a consequence of):         </td> </tr> <tr> <td>b.</td> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="6">Due to (or as a consequence of):</td> </tr> </table> |  |   |  |  |   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>PENETRATING LACERATION OF THE LEFT CHEST</b><br>Due to (or as a consequence of): |  |  |  |  |  | b. | Due to (or as a consequence of): |  |  |  |  |  | c. | Due to (or as a consequence of): |  |  |  |  |  | d. | Due to (or as a consequence of): |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.   | <b>PENETRATING LACERATION OF THE LEFT CHEST</b><br>Due to (or as a consequence of):                          |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | b.   | Due to (or as a consequence of):   |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | c.   | Due to (or as a consequence of):   |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
|   | d.   | Due to (or as a consequence of):   |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>found 4/23/97</b>   |   | 28b. Time of Injury<br><b>found 5:55<sup>M</sup></b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>subject struck by blunt object</b> |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>found on side of road</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Harmons Road (Severn)</b> |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |  |   | 29c. License number<br><b>O.C.M.E.</b>               |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 23, 1997</b>                                |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201</b>  |  |  |   |  |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  |  |   | 32. Registrar's Signature<br>                        |  |   |  |  |   |    |   |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |  |    |                                  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12910

## Certificate of Death

Reg. No.

|  |  |  |  |                                |  |
|--|--|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DARLENE DIXON</b>   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 24, 1997</b>  |                                | 3. Time of Death<br><b>22:45 PM</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SHOCK TRAUMA UNIT</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-84-9157</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>35</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>2-13-62</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>BALTO. Md</b>   |                                |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |  | 10a. State<br><b>Maryland</b>  |                                | 10b. County<br><b>N/A</b>  |
|  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                |  |
|  | 10e. Street and Number<br><b>1803 W. Saratoga St.</b>  |  | 10f. Zip Code<br><b>21223</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify <b>Afro American</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)                     |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Correction officer</b>   |
|  | 16b. Kind of Business/Industry<br><b>State</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>HERMAN G. Lyles</b>  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jerelean Smith</b>   |
|  | 19a. Intendant's Name/Relationship (Type, Print)<br><b>Mrs Sylvia Harris</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>225 N. Monroe Street Apt 3 Balto. Md 21223</b> |                                |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial</b>  |                                | 20c. Location - City or Town, State<br><b>Baltimore Md.</b>  |
|  | 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>   |  | 22. Name and Address of Facility<br><b>Joseph L. Russ FUNERAL HOME</b><br><b>2926 W. North Ave. Baltimore Md 21216</b>                             |                                |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Stab Wounds</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |                                |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |                                |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |                                |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  |                                |  |
| 28a. Date of Injury (Month, Day Year)<br><b>4-24-97</b>  |  |  |  |                                |  |
| 28b. Time of Injury<br><b>22 08M</b>   |  |  |  |                                |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |                                |  |
| 28d. Describe how injury occurred<br><b>subject stabbed</b>  |  |  |  |                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>street</b>  |  |  |  |                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1800 Bk W. Saratoga St</b>  |  |  |  |                                |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |                                |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |  |  |                                |  |
| 29c. License number<br><b>OCME</b>   |  |  |  |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>APRIL 25, 1997</b>   |  |  |  |                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |  |  |  |                                |  |
| 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12911

|   |  |                           |   |  |  |  |   |  |   |   |  |
|---|--|---------------------------|---|--|--|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Josephine Devoe</i>                                     |                           |   |  |  |  | 2. Date of Death<br>Month <i>April</i> Day <i>26</i> Year <i>1997</i> |  | 3. Time of Death<br><i>3<sup>25</sup> p</i>                             |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice at Mercy</b> |                           |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |  | 4c. County of Death<br><b>N/A</b>                                       |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>195-20-5773</b>  |                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB 12, 1921</b>            |  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>                   |   |  |
|   | Usual Residence of Decedent  |                           |   |  |  |  |   |  |   |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b> |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |  |
| 10e. Street and Number<br><b>3037 Kenyon Avenue</b>   |  |                           |   | 10f. Zip Code<br><b>21213</b>  |  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |                           | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Person</b>   |  |  |   | 16b. Kind of Business/Industry<br><b>Retail</b>  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Anthony Falandys</b>  |  |                           |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Cirek</b>   |   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Stanley E. DeVoe/Husband</b>   |  |                           |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3037 Kenyon Ave. Baltimore, MD 21213</b>   |   |  |   |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 4/28/97</b>   |  |  |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Edward A. Gregorchik</i><br><b>Edward A. Gregorchik</b>   |  |                           |   |  |  | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>   |   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Lymphoma</i><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |                           |   |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><i>10 years</i> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                           |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |  |
|   |  |                           |   |  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |
|   |  |                           |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                           |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Stella Maris at Mercy Hospice</i> |  |  |   |  |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined  |  |                           |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred<br><b>Hospice</b>             |  |
|   |  |                           |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
| 29e. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                           |   |  |  |  |   |  |   |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |                           |   |  |  | 29c. License number<br><b>040480</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>April 26, 1997</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FERNANDO J. FERRO, MD</b>  |  |                           |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>5810 Belair Rd<br/>Baltimore, MD 21206</b>  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  |                           |   | 32. Registrar's Signature<br><i>[Signature]</i><br><b>John Davidson-Randall</b>  |  |  |   |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

JA



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

### Certificate of Death

Reg. No.

97 12912

|   |  |   |  |   |  |   |   |   |   |   |  |  |  |
|---|--|---|--|---|--|---|---|---|---|---|--|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>                                  |  | 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL ANTHONY DISENA</b>   |  |   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 27, 1997</b>   |   | 3. Time of Death<br><b>0130AM</b>   |  |  |  |
|   |  | 4a. Facility Name (If not institution, give street and number)<br><b>SEWELLS ORCHARD ROAD</b>   |  |   |  |   |   | 4b. City, Town, or Location of Death<br><b>COLUMBIA</b>   |   | 4c. County of Death<br><b>HOWARD COUNTY</b>   |  |  |  |
| <b>Funeral<br/>Director</b>   |  | 5. Social Security Number<br><b>216-52-1513</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>42 Yrs.</b>  |   | 8. Date of Birth (Month, Day, Year)<br><b>January 18, 1955</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
|   |  | Usual Residence of Decedent   |  |   |  |   |   |   |   |   |  |  |  |
| <b>To Be Completed by Funeral Director</b>                                  |  | 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>Howard County</b>   |  | 10c. City, Town or Location<br><b>Columbia</b>  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                            |  |  |  |
|   |  | 10e. Street and Number<br><b>6710 Summer Rambo Court</b>  |  |   |  | 10f. Zip Code<br><b>21045</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |   |  |  |  |
|   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |   |  |  |  |
|   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>business owner</b>  |  |   | 16b. Kind of Business/Industry<br><b>automotive parts manufacture</b> |   |   |   |  |  |  |
| <b>Physician<br/>/Medical<br/>Examiner</b>                                  |  | 17. Father's Name (First, Middle, Last)<br><b>Peter J. DiSena</b>   |  |   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eva K. Palazzala</b>  |   |   |  |  |  |
|   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ms. Susan DiSena/spouse</b>  |  |   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6710 Summer Rambo Court, Columbia, Maryland 21045</b> |   |   |  |  |  |
|   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | Data<br><b>1 MAY 97</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |   |   |  |  |  |
|   |  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>Ellicott City, Maryland 21043</b>   |   |   |   |   |  |  |  |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b> |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="margin-left: 40px;"> <b>a. Multiple Injuries</b><br/>Due to (or as a consequence of):         </div> <div style="margin-left: 40px;"> <b>b.</b><br/>Due to (or as a consequence of):         </div> <div style="margin-left: 40px;"> <b>c.</b><br/>Due to (or as a consequence of):         </div> <div style="margin-left: 40px;"> <b>d.</b> </div> |  |   |  |   |   |   |   |   |  | Approximate Interval Between Onset and Death |  |
|   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |   |  |   |   |   |   |   |  |  |  |
|   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |   |   |   |   |   |  |  |  |
|   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of causa of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |   |   |  |  |  |
| <b>State Registrar</b>  |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b> |  |   |   |   |   |   |  |  |  |
|   |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>4-27-97</b>  |  | 28b. Time of Injury<br><b>1:21 AM</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred<br><b>motor vehicle accident</b>  |  |  |  |
|   |  |   |  |   |  | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>street</b>   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Sewell's Orchard Rd Howard Co., MD</b> |  |  |  |
|   |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br><b>O.C.M.E.</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 27, 1997</b>  |  |  |  |
| <b>Division of Vital Records, P.O. Box 68760,</b>                           |  | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute</b><br><b>111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |   |   |   |   |   |  |  |  |
|   |  | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  | 32. Registrar's Signature<br>   |  |   |   |   |   |   |  |  |  |



97 12913

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAYNE MARLENE DENEAU</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>APRIL</b> DAY <b>25</b> YEAR <b>97</b>  |  | 3. TIME OF DEATH<br><b>11:50 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-60-4443</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>43</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Oct. 20, 1953</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Greece</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>15001 Columbine Way</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>15001 Columbine Way</b>   |  |
| 10f. ZIP CODE<br><b>20853</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 8+) <b>4</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own home</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Michael Leonidas Kaitis</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Katie Karangelina</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Michael Kaitis, father</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4705 Flower Valley Drive, Rockville, Md. 20853</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Cemetery 4-30</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ann S. Hutchins</b>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASPHYXIA</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>a. <b>DEPRESSION</b><br>b. <b>ACUTE</b><br>c. <b>INDEK</b><br>d. |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>APRIL 24 97</b>   |  |  |  |
| 28b. TIME OF INJURY<br><b>P M</b>   |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURED<br><b>FOUND IN CAR</b>   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>#10</b>  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Francis C. Mayle</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>DO7099</b>   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>APRIL 25 97</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRANCIS C. MAYLE 10215 FERNWOOD RD BETHESDA MD 20817</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 29 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Russell</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12914

## Certificate of Death

Reg. No.

|  |  |  |   |                                |  |  |  |  |
|--|--|--|---|--------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>CALVIN ELLEN   |  |   |                                | 2. Date of Death<br>Month Day Year<br>04 24 97   |  | 3. Time of Death<br>5:17 PM                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>UNIVERSITY OF MARYLAND MEDICAL CTR   |  |   |                                | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>BALTIMORE CITY                            |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-74-8550   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>34 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>June 26, 1962                                 | 9. Birthplace (State or Foreign Country)<br>Maryland             |  |
|  | Usual Residence of Decedent<br>10e. State Maryland 10b. County N/A 10c. City, Town or Location Baltimore   |  |   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br>20 St. Paul Street APT 5E  |  | 10f. Zip Code<br>21202  |                                | 10g. Citizen of What Country?<br>USA   |  |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Caterer  |                                | 16b. Kind of Business/Industry<br>Self-employed  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Calvin Ellen  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia Robinson   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Virginia Reynolds (mother)  |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1348 Cleveland St. Balto. Md. 21230   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sacred Heart  |                                | 20c. Location - City or Town, State<br>5/2/97 Balto. Md.   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Joseph L. Russ  |  | 22. Name and Address of Facility<br>Joseph L. Russ Funeral Home<br>2222 W. North Ave. Balto. Md. 21216  |                                |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. INTRACRANIAL HEMORRHAGE<br>Due to (or as a consequence of):<br>b. COAGULOPATHY<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                |  |  |  | Approximate Interval Between Onset and Death<br>4 HOURS  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HIV INFECTION<br>SEPSIS  |  |   |                                |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>Shana E. Weiss MD                     |   | 29c. License number<br>P10231  |  | 29d. Date signed (Month, Day, Year)<br>4/24/97                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>SHANA WEISS, M.D. 22 S. GREEN ST. BALTIMORE, MD 21201  |  |  |   |                                |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>04 29 1997  |  | 32. Registrar's Signature<br>J. Harrison-Jandell                               |   |                                |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12915

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gary D. Edwards

2. Date of Death

Month Day Year

April 26 1997

3. Time of Death

9:15 A.M.

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

216 62 3506

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 1, 1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

14301 Sinepuxent Avenue

10f. Zip Code

21842

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Keystone Electric

17. Father's Name (First, Middle, Last)

James G. Edwards Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Kathleen G. Wetzel

19a. Informant's Name/Relationship (Type, Print)

Cecelia A. Edwards / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14301 Sinepuxent Avenue Ocean City, Maryland 21842

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Memorial Park

Date

4/29/97

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

*Richard E. Davis*

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *upper gastrointestinal bleeding*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*10 days*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*hepatic cirrhosis*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Robert D. Davis*  
physician

29c. License number

H44287

29d. Date signed (Month, Day, Year)

4/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert D. Davis

9733 Hildbury Drive

Berlin, MD

State Registrar

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

*Julia Davidson-Randall*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12916

ITEM: 20b per FH 5-1-97 ech

|  |  |                           |   |   |  |  |  |
|--|--|---------------------------|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedant's Name (First, Middle, Last)<br><i>Jean P. Foust</i>   |                           |   | 2. Date of Death<br>Month <i>April</i> Day <i>27</i> Year <i>97</i>   |  | 3. Time of Death<br><i>0530 am</i>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>ST. AGNES HOSPITAL</i>  |                           |   | 4b. City, Town, or Location of Death<br><i>BALTIMORE</i>  |  | 4c. County of Death<br><i>n/a</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>207-12-6927</i>  |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>73</i> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><i>DEC. 22, 1923</i>                   |
|  | 9. Birthplace (State or Foreign Country)<br><i>MARYLAND</i>  |                           |   |   |  |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |                           |   |   |  |  |  |
|  | 10a. State<br><i>MD</i>  | 10b. County<br><i>n/a</i> | 10c. City, Town or Location<br><i>BALTIMORE</i>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><i>801 WINTERS LANE</i>  |                           |   | 10f. Zip Code<br><i>21228</i>   |  | 10g. Citizen of What Country?<br><i>UNITED STATES</i>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>BLACK</i>          |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+)   |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>LABORER</i>                       |   | 16b. Kind of Business/Industry<br><i>FACTORY</i>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>CLARENCE JOHNSON</i>   |                           |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>ANNA PALMER</i>   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>LENARD FOUST-SON</i>  |                           |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2006 WILDLIFE DRIVE, BALTIMORE, MD 21244</i>  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>ARBUTUS MEMORIAL PARK</i>  |   | 20c. Location - City or Town, State<br><i>ARBUTUS, MD</i>  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Gala March</i>   |                           | 22. Name and Address of Facility<br><i>WM. C. MARCH FH.-4300 WABASH AVENUE</i>  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Bronchitis Aspiration</i><br>Due to (or as a consequence of):<br><i>Carcinoma Lung</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>Dementia</i><br>Due to (or as a consequence of): |                           |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |                           |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                           |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                           |   |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                           |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |                           | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|  | 28d. Describe how injury occurred  |                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |                           |   |   |  |  |  |
| State Registrar  | 29b. Signature and title of certifier<br><i>[Signature]</i>  |                           |   | 29c. License number<br><i>D28044</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>4/27/97</i>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>MIKE [Signature] M.D., M. REITHMAN M.D. ST. AGNES, MD Hosp.</i>   |                           |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>APR 29 1997</i>  |  |                           | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12917

|  |  |  |   |  |  |   |  |   |  |  |
|--|--|--|---|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>KA - Ree</b>  |  |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>25</b> Year <b>1997</b>  |   |  |   | 3. Time of Death<br><b>4:34 P.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   |  |   | 4c. County of Death<br><b>NA</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-92-9286</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>18</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>03-23-79</b>       |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
|  | Usual Residence of Decedent  |  |   |  |  |   |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>209 North Rose Street</b>   |  |   |  | 10f. Zip Code<br><b>21224</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                  |   |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th Grade</b> College (1-4 or 5+) <b>NA</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Unemployed</b>   |   |  | 16b. Kind of Business/Industry<br><b>Never worked</b>                   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Clinton L. Harris</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jeanneen Fayall</b>  |   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jeanneen Fayall</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21224</b><br><b>209 North Rose Street Baltimore, Maryland</b>                                   |   |  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Cemetery</b>   |  | Data<br><b>04-30-97</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b> |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C March FH 1101 E. North Avenue</b>  |   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Injuries</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |  |   |  |  |   |  |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |   |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |  |   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |  |   |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |   |  |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>4-25-97</b> |   | 28b. Time of Injury<br><b>1615 P M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>pedestrian struck by bus</b>    |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>street</b>  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2500 E. Fayette St Baltimore, Md</b> |  |   |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |  |   | 29c. License number<br><b>O.C.M.E.</b>   |  |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 26, 1997</b> |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chuter 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |   |  |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b><br><i>[Signature]</i>  |  |  |   |  |  |   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12918

## Certificate of Death

Reg. No.

|   |  |   |   |  |   |   |  |   |  |
|---|--|---|---|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Dorothy Estella Ford</b>  |   |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>27</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>9:25 am</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3304 Chesley Avenue</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>N/A</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-05-1747</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>November 25, 1915</b>                                | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|   | Usual Residence of Decedent  |   |   |  |   |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>3304 Chesley Avenue</b>   |   |   |  | 10f. Zip Code<br><b>21234</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Henry E. Becker, Sr.</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Norma Virginia Jory</b>   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Roger Dennis Ford/Son</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>203 A Seneca Way Havre de Grace, Maryland 21078</b>                                       |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Piece of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | Date<br><b>4/29/97</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                              |   |  |
|   | 21. Signature of Funeral Service Licensee <b>Brian A. Willem</b><br><b>Brian A. Willem</b>   |   |   |  | 22. Name and Address of Facility <b>Leonard J. Ruck Funeral Home, Inc.</b><br><b>5305 Harford Road Baltimore, Maryland 21214</b>  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ASCVD</b><br>Due to (or as a consequence of):<br><b>b. Furosemide</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>103P X yrs.</b><br><b>COPD Acutely decompensated</b> |   |   |  |   |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>103P X yrs.</b><br><b>COPD Acutely decompensated</b>   |  |   |   |  |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Michael J. Willem</b>   |   |  |   |   |  |   |  |
| 29c. License number<br><b>227693</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/28/97</b>   |   |  |   |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael J. Willem 6530 Waltham Ave Baltimore</b>   |  |   |   |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |   |  |   |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12919

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Samuel E. Graham Sr.</b>  |   |   | 2. Date of Death<br>Month: <b>April</b> Day: <b>26</b> Year: <b>1997</b>  |  | 3. Time of Death<br><b>1:10 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Caton Manor Nursing Home Baltimore</b>  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>226-20-3722</b>  |   | 6. Sex<br><b>1</b> M <b>2</b> F   | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  | <input type="checkbox"/> Under 1 Year<br>Months Days   | <input type="checkbox"/> Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Month: <b>Jan.</b> Day: <b>30</b> Year: <b>1923</b>  |
|   | Usual Residence of Decedent  |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>N/A</b>                                 | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>294 Eudowood Lane</b>   |   |   | 10f. Zip Code<br><b>21286</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Watchmaker</b>  |   | 16b. Kind of Business/Industry<br><b>Jewelry</b>   |  |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>Robert Graham</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ophelia Graham Green</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ms. D. Janet West (daughter)</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>603 Hillview Rd. Balto. Md. 21225</b> |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>  |   | 20c. Location - City or Town, State<br><b>4/30/97 Owings Mills, Md.</b>  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>   |   | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md. 21216</b>  |   |  |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute Renal Failure</b><br>Due to (or as a consequence of): <b>Carcinoma of Prostate</b> |   |   |   |  |  | Approximate Interval Between Onset and Death<br><b>1 week</b><br><b>6 Months</b>   |
|   | 23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Carcinoma of Prostate</b><br>Due to (or as a consequence of):                                    |   |   |   |  |  |  |
|   | 23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Carcinoma of Prostate</b><br>Due to (or as a consequence of):                                    |   |   |   |  |  |  |
|   | 23d. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Carcinoma of Prostate</b><br>Due to (or as a consequence of):                                    |   |   |   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 28d. Describe how injury occurred   |  |   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)         | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Whitney M. Attending Doctor</b>   |  |   |   | 29c. License number<br><b>D21684</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4-28-97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>C.V. CRIAR-M.D. 8109 RITCHIE HWY PASADENA, MD 21122</b>  |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b> |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 12920

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY GILMORE

2. Date of Death

Month Day Year  
APRIL 27 97

3. Time of Death

12:37 AM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral  
Director

5. Social Security Number

213-26-6228

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
3-21-1929

9. Birthplace (State or Foreign Country)

ACCOMACK, VA

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

2 ☒ Yes 2 ☐ No

10e. Street and Number

2121 Windsor Garden Lane

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Afro American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th 8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Vailes D. Knox

18. Mother's Name (First, Middle, Maiden Surname)

Naomi Madre

19a. Informant's Name/Relationship (Type, Print)

Mrs. Edith Parker (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1533 Uphire Rd Baltimore Md. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Aebulus Mem. Park

Date

9/97

20c. Location - City or Town, State

BALTIMORE Md

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home

2202 W. North Ave. Baltimore Md 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DIVERTICULITIS

Due to (or as a consequence of):

UNKNOWN

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

• END-STAGE RENAL FAILURE (ON HEMODIALYSIS)

• TYPE II DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

JL Russ MD

29c. License number

A52402321MC9032

29d. Date signed (Month, Day, Year)

APRIL 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL F. CHANG MD; SINAI HOSPITAL OF BALTIMORE; 2401 WEST BELVEDERE; BALTIMORE MD

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Registrar-Attending Physician: The law requires that the death certificate be executed within 48 hours of death.

To the Funeral Director: This certificate has been signed by the attending physician and completed in accordance with the law. This certificate should be attached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 23 Part I 5-14-97 Film G747 W.H. Per Doctor

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12921

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>RUTH MARGARET GRAY   |  |   |  | 2. Date of Death<br>Month Day Year<br>APRIL 25, 1997   |  | 3. Time of Death<br>7:50pm  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>LORIE NURSING HOME   |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>n/a  |  |
| Funeral<br>Director  | 5. Social Security Number<br>218-42-3155   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>91 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>APR. 22, 06  |  |
|  | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |  | 10a. State<br>MD  |  | 10b. County<br>n/a   |  | 10c. City, Town or Location<br>BALTIMORE  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>601 S. CHARLES ST.  |  | 10f. Zip Code<br>21230   |  | 10g. Citizen of What Country?<br>UNITED STATES  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:             |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK  |  |
| To Be Completed by Physician/Medical Examiner                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7 th   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>DOMESTIC   |  | 16b. Kind of Business/Industry<br>in home  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>JAMES MILLER  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>LILLIAN DOBSON   |  | 19a. Informant's Name/Relationship (Type, Print)<br>THOMAS HUTCHINSON  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2207 WINDSOR AVE., BALTIMORE, MD 21216 |  |
| Physician<br>/Medical<br>Examiner  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>CHESTERFIELD CEM.   |  | 20c. Location - City or Town, State<br>4-30-97 CENTREVILLE, MD   |  | 21. Signature of Funeral Service Licensee<br><i>Sala March</i>  |  |
|  | 22. Name and Address of Facility<br>MARCH FH.-4300 WABASH AVE. BALTO., D 21215   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Renal Failure due to<br>Dua to (or as a consequence of):<br>Arteriosclerotic Cardiovascular Disease<br>b. Dua to (or as a consequence of):<br>c. Dua to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br>years  |  |   |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Atherosclerotic Cardiovascular Disease<br>Anemia<br>Dementia   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner                                | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |   |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner                                | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Fredrick Sirkis M.D.</i>  |  | 29c. License number<br>D22685  |  | 29d. Date signed (Month, Day, Year)<br>4/28/97  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>FREDRICK SIRKIS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222   |  |   |  | 31. Date filed (Month, Day, Year)<br>APR 29 1997   |  |   |  |
|  | 32. Registrar's Signature<br><i>Fredrick Sirkis</i>  |  |   |  |  |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12922

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VERA GRAHAM

2. Date of Death

Month Day Year  
APRIL 22, 1997

3. Time of Death

3:20 AM

4a. Facility Name (If not institution, give street and number)

702 HOMESTEAD STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-50-1328

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 6, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

702 Homestead Street 2nd Front

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

James Cravens

18. Mother's Name (First, Middle, Maiden Surname)

Mary Pearl Cravens

19a. Informant's Name/Relationship (Type, Print)

Sabrina Cravens (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1527 Wadsworth Way Baltimore, Md 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Voshells Mem Gargen 4/28/97 Baltimore, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Caple Funeral Service

5502 Winner Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. CIRRHOSIS OF LIVER AND CHRONIC PANCREATITIS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. CHRONIC ALCOHOLISM

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending2 ☐ Accident

Investigation

3 ☐ Suicide6 ☐ Could not be4 ☐ Homicide

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury et

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

APRIL 22, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed  
within 48 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12923

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Gavin

2. Date of Death

Month Day Year  
April 26 1997

3. Time of Death

5:00pm

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

216-32-6467

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 22, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

117 West 27th Street

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk-Food Stamp Program

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Joseph Martin Gavin

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Weitzel

19a. Informant's Name/Relationship (Type, Print)

George E. Gavin, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3605 Malden Avenue, Baltimore, Md 21211

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Green Mount Cemetery

Date

5/1/97

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home  
3818 Roland Avenue, Baltimore, Maryland 2121123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Carbon dioxide narcosis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

6 hours

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

many years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Right-sided heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Kathryn N. Walcott, M.D.

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

April 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kathryn N. Walcott, M.D., Union Memorial Hosp., Dept. of Medicine, 201 E. University Pkwy., Baltimore, MD 21218

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

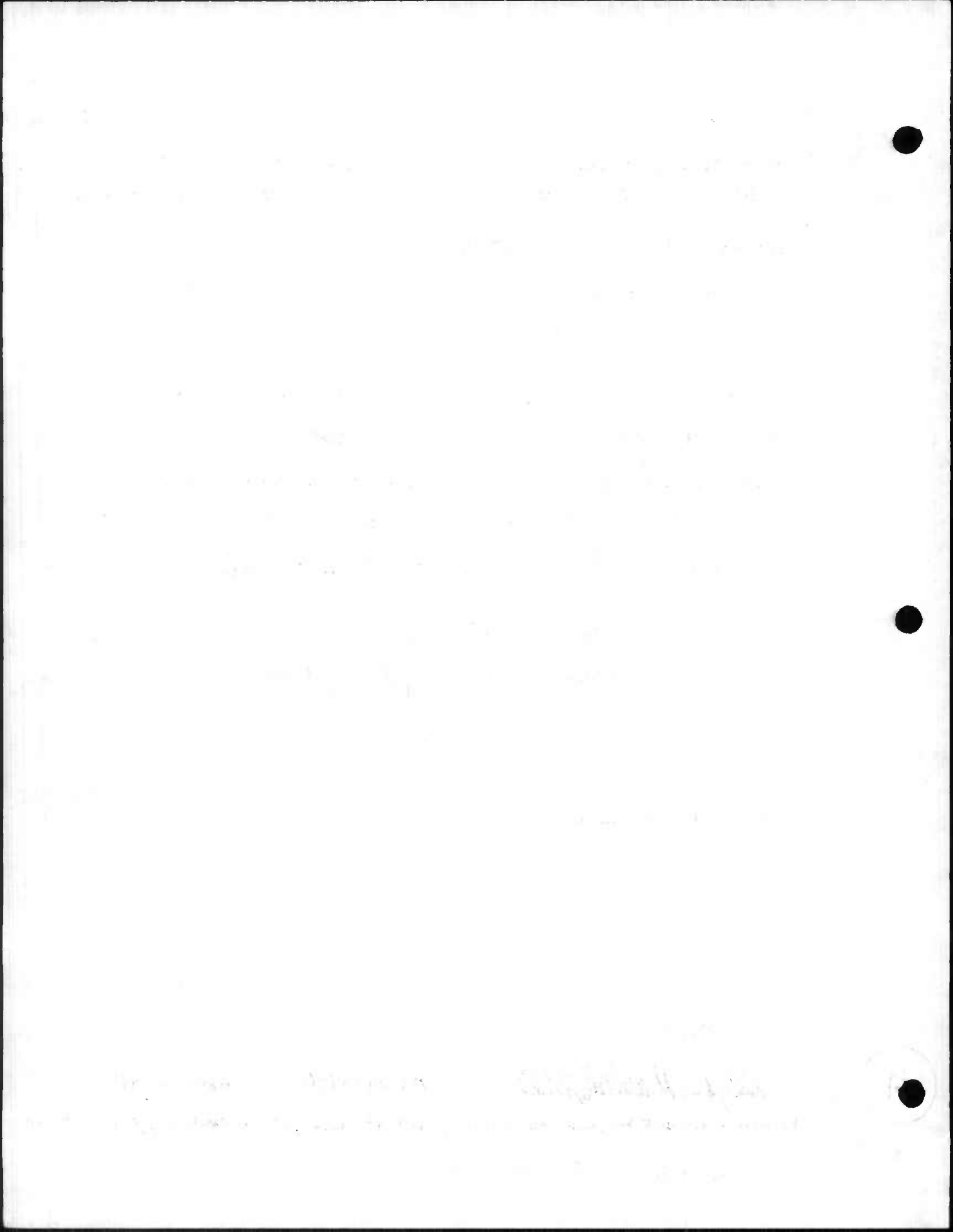
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12924

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Jean Henderson

2. Date of Death

April 22, 1997

3. Time of Death

0245

4a. Facility Name (If not institution, give street and number)

Hospice of Baltimore-Gilchrist Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

237-44-4128

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 3, 1934

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

124 Driftwood Court

10f. Zip Code

21085

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Real Estate Broker

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Buford Theodore Sitton

18. Mother's Name (First, Middle, Maiden Surname)

Emmerline Dover

19a. Informant's Name/Relationship (Type, Print)

Linda Henderson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

680 Yorkshire Drive, Edgewood, MD. 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

4/25/97

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of the hypopharynx

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

None

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D25205

29d. Date signed (Month, Day, Year)

April 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W A Riley GEMS 6701 N. Charles St. Balto. Md 2120x

31. Date filed (Month, Day, Year)

APR 29 1997

*[Signature]*

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Medical or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12925

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Priscilla S Hines

2. Date of Death

Month Day Year  
APRIL 27 1997

3. Time of Death

5:47

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-44-3945

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV. 2, 1944

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2516 E. EAGER STREET

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give X  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: NEGRO

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9THCollege (1-4or 5+)  
N/A16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

BENJAMIN WIGGINS

18. Mother's Name (First, Middle, Maiden Surname)

ELOISE DAVENPORT

19a. Informant's Name/Relationship (Type, Print)

SHARON HINES - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1722 E. OLIVER STREET BALTO, MD. 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MT. ZION CEM.

Date

MAY 3, 1997 BALTO, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Calvin B. Scruggs, Jr.

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Septic Shock

Due to (or as a consequence of):

b. Pneumonia, hypoxia, acidemia

Due to (or as a consequence of):

c. Sarcoidosis

Due to (or as a consequence of):

d. Aspergillosis

Approximate  
Interval Between  
Onset and Death

1 day

1 week

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David G. Friedenson MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

4/27/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David G. Friedenson Johns Hopkins Hospital Wolfe St Baltimore, MD

State  
Registrar

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 48 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





97 12926

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12927

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL HENSON

2. Date of Death  
Month Day Year

4 27 97

3. Time of Death

11:28 A

4a. Facility Name (If not institution, give street and number)

RAVEN WOOD Neg + Rehabilitation

4b. City, Town, or Location of Death

Baltimore MD

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-64-0543

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6-3-55

9. Birthplace (State or Foreign Country)

Baltimore

Usual Residence of Decedent

10a. State

Md

10b. County

Na

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

501 W. Franklin Street

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10th GradeCollege (1-4or 5+)  
NA16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

various trades

17. Father's Name (First, Middle, Last)

Paul Henson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Olive M. Turner

19a. Informant's Name/Relationship (Type, Print)

Olive M. Parker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Apt. 4H  
633 N. Aisquith Street Baltimore, Maryland

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greenmount Cemetery

Date

04-30-97

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licenses

J. J. Chy

22. Name and Address of Facility

Baltimore, Maryland  
WM.C March FH 1101 E. North Avenue 2120223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Toxoplasma Encephalitis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Acquired Immuno deficiency Syndrome

Due to (or as a consequence of):

more than  
5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① AIDS wasting ② Heroin dependency

③ Chronic Persistent Hepatitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

NONE

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Robert Kent MD

29c. License number

D06966

29d. Date signed (Month, Day, Year)

4/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Kent MD 1001 N. Cathedral ST. Baltimore, Md 21201

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text at the top of the page, possibly a header or title.

Main body of handwritten text, consisting of several lines of script.

Handwritten text at the bottom of the page, possibly a footer or concluding remarks.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12928

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |
|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Reginald Edward Harris</b>   |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>22</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>1930</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>JOHN DEATON HOSPITAL</b>   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-46-1639</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>OCT 3, 1946</b>                        |
|  | 9. Birthplace (State or Foreign Country)<br><b>BALTIMORE, MD.</b>   |   |  |  |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>BALTIMORE</b>  |  |
|  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
|  | 10e. Street and Number<br><b>3020 ASCENSION STREET</b>  |   | 10f. Zip Code<br><b>21225</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:        |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>AFRO AMERICAN</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                              |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MAIL PLANT</b>   |  |
|  | 16b. Kind of Business/Industry<br><b>HARTE-HANKS DIRECTOR MK</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>HAZEL HARRIS</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MATTIE HARRIS</b>  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MATTIE HARRIS MOTHER</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3020 ASCENSION STREET, BALTIMORE, MARYLAND 21225</b> |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>4/29/97 BALTIMORE, MARYLAND</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   | 22. Name and Address of Facility<br><b>ESTEP BROTHER FUNERAL HOME, P.A.<br/>1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217</b>                              |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Anoxic encephalopathy</b><br>Due to (or as a consequence of):<br>b. <b>Cerebrovascular accident</b><br>Due to (or as a consequence of):<br>c. <b>Seizure disorder</b><br>Due to (or as a consequence of):<br>d. |   | Approximate Interval Between Onset and Death<br><b>1 month</b><br><b>1 month</b><br><b>1 month</b>   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D34974</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>04/23/97</b>                           |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>5865 Robert Oliver place, #121, Columbia, MD 21045</b>  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12929

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ANNA M. INGRASSIA</b>  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>27</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>9:20AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL ASSN GLEN BURNIE</b>  |  | 4b. City, Town, or Location of Death<br><b>ANNE ARUNDEL</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |
| 5. Social Security Number<br><b>212 46 8075</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   |  |
| 8. Data of Birth (Month, Day, Year)<br><b>Aug. 21, 1910</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 10e. Street and Number<br><b>224 Poplar Avenue</b>  |  | 10f. Zip Code<br><b>21061</b>   |  | 10g. Citizen of What Country?<br><b>U.S.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>                        |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Guisepppe Picciurro</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria D'Alesandro</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Frank Ingrassia / son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>224 Poplar Avenue Glen Burnie, Maryland 21061</b> |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>5/1/97 Baltimore, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Richard E. Davis</b>  |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>                                      |  |  |  |

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |
|---|--|---|--|
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  | Approximate Interval Between Onset and Death  |  |
| a. <b>PNEUMONIA</b>   |  | <b>2 weeks</b>  |  |
| b. <b>CONGESTIVE HEART FAILURE</b>  |  | <b>3 years</b>  |  |
| c. <b>DIABETES MELLITUS</b>   |  |   |  |
| d.  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |  |
| 28b. Time of Injury<br><b>1</b> Yes <b>2</b> No   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |
| 29b. Signature and title of certifier<br><b>Agata MD</b>  |  | 29c. License number<br><b>D43977</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>APRIL 27 1997</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Charm Dikert, 301 Hospital Drive, Glen Burnie, MD 21061</b>  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |

State  
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





asp

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12930

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>DIANE A. JONES  |  | 2. Date of Death<br>Month Day Year<br>APRIL 25 1997   |  | 3. Time of Death<br>10:25 p.m.   |
|   | 4a. Facility Name (If not institution, give street and number)<br>5500 BLK PERRING PARKWAY  |  | 4b. City, Town, or Location of Death<br>BALTIMORE   |  | 4c. County of Death<br>NA  |
| Funeral<br>Director   | 5. Social Security Number<br>218-64-6434  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>41 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>Aug. 31, 1955 | 9. Birthplace (State or Foreign Country)<br>md   |
|   | Usual Residence of Decedent   |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD  | 10b. County<br>NA  | 10c. City, Town or Location<br>Baltimore  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br>1903 E. BELVEDERE AVE.  |  | 10f. Zip Code<br>21239  |  | 10g. Citizen of What Country?<br>USA   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th College (1-4or 5+) 2yrs.                      |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Microfilm Technician   |  | 16b. Kind of Business/Industry<br>B & E   |  |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br>Joseph Moore   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Genevieve Forrester  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>James J. Jones, Jr.   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1903 E. Belvedere Ave., Balto. MD #39            |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Garrison Forest   |  | 20c. Location - City or Town, State<br>5-1-97 Owings Mills, MD   |
|   | 21. Signature of Funeral Service Licensee<br>Phyllis B. Harris  |  | 22. Name and Address of Facility<br>Wm. C. March - 4300 Wabash Ave.   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Multiple Injuries<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |  |
| 26. Piece of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE   |   |  |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   |  |   |  |  |
| 28a. Date of Injury (Month, Day, Year)<br>4-25-97   |   |  |   |  |  |
| 28b. Time of Injury<br>2225 M   |   |  |   |  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |  |
| 28d. Describe how injury occurred<br>Passenger in auto accident   |   |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>STREET  |   |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>5500 Blk. Perring Pkwy  |   |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |
| 29b. Signature and title of certifier<br>[Signature] MD   |   |  |   |  |  |
| 29c. License number<br>O.C.M.E  |   |  |   |  |  |
| 29d. Date signed (Month, Day, Year)<br>APRIL 26, 1997   |   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>JASON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1997  |   |  |   |  |  |
| 32. Registrar's Signature<br>Julia Davidson-Randall   |   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12931

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Willie J. Johnson

2. Date of Death

April 23 1997

3. Time of Death

130p.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

251-54-2019

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 15, 1934

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3203 Glen Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10<sup>th</sup> grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

NSA

17. Father's Name (First, Middle, Last)

William Williams

18. Mother's Name (First, Middle, Maiden Surname)

Carolina Johnson

19a. Informant's Name/Relationship (Type, Print)

Annie Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3203 Glen Avenue, Baltimore, Maryland 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

David Ridge Cemetery 4-28-97 Pikesville, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Joseph H. Brown Jr. Funeral Home, P.A.

2140 N. Fulton Avenue, Baltimore, Maryland 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Colon Carcinoma

Approximate Interval Between Onset and Death

07/96

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] Carlos J. Borrás

29c. License number

P103 74

29d. Date signed (Month, Day, Year)

April 23 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2201 W. Belvedere Ave., Baltimore, MD. 21215.

State  
Registrar

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

[Signature] John Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Division of Vital Records, P.O. Box 68760,



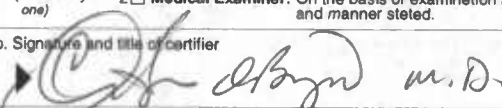
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12932

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MARY JACKSON</b>   |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>26</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>7:30am</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1114 Crain Highway</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-36-2572</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>100</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>August 25, 1896</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 10e. Street and Number<br><b>1114 Crain Highway</b>   |  | 10f. Zip Code<br><b>21061</b>  |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8<sup>th</sup> grade</b> College (1-4 or 5+)   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>Own home</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Henry Brooks</b>   |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rebecca Jennings</b>  |  |   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mae W. Hardy (Daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1114 Crain Highway, Glen Burnie, Maryland</b>  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Saint Rest Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>4-30-97 Hanover, Maryland</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>2140 N. FULTON AVENUE, BALTIMORE, MD. 21217</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div> <p>a. <b>Hypertensive Arterio Sclerosis Cardiovascular</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Cerebrovascular accident</b><br/>Due to (or as a consequence of):</p> <p>c. <b>Seizure disorder</b><br/>Due to (or as a consequence of):</p> <p>d. <b>Diabetes mellitus</b><br/>Due to (or as a consequence of):</p> </div> </div> |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>00000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4/28/97</b>  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Christopher de Borja 3708 Mt Rd. Pasadena</b>  |  |   |  |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  |   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12933

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedant's Name (First, Middle, Last)<br><i>Benny F. Jones</i>  |  |   |  | 2. Date of Death<br>Month <i>April</i> Day <i>17</i> Year <i>1997</i>   |  | 3. Time of Death<br><i>03:30 Am</i>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Baltimore Veterans Administration Medical Center</i>  |  |   |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |  | 4c. County of Death<br><i>N/A</i>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><i>499-22-9550</i>  |  | 6. Sex<br><i>M</i> <input checked="" type="checkbox"/> <i>F</i> <input type="checkbox"/>  |  | 7. Age (In yrs. last birthday)<br><i>70</i> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><i>Nov. 19, 1926</i>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><i>MISSOURI</i>  |  | 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>N/A</i>   |  | 10c. City, Town or Location<br><i>BALTIMORE</i>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 10e. Street and Number<br><i>1411 Division Street</i>   |  | 10f. Zip Code<br><i>21217</i>   |  |
|   | 10g. Citizen of What Country?<br><i>USA</i>  |  |   |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>1945-1948</i> |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i>  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>   |  | 15. Decedent's Education (Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i>                               |  |
|   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>UNKNOWN</i>   |  |   |  | 16b. Kind of Business/Industry<br><i>UNKNOWN</i>  |  | 17. Father's Name (First, Middle, Last)<br><i>UNKNOWN</i>   |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>UNKNOWN</i>  |  |   |  | 19. Informant's Name/Relationship (Type, Print)<br><i>JACK C. HUMPHRIES</i>   |  |   |  |
|   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>HEALTH BENEFIT SERVICES<br/>VA Maryland Health Care Service Baltimore, Md 21201</i>  |  |   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Garrison Forest Veterans Cem</i>  |  |   |  | 20c. Location - City or Town, State<br><i>4100/97</i>   |  | 20d. Date<br><i>4/18/97</i>   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><i>CHATHAM - HOME Funeral Home<br/>5240 REISTERSTOWN ROAD<br/>BALTIMORE, Maryland 21215</i>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | 23b. Approximate Interval Between Onset and Death<br><br><i>metabolic and respiratory acidosis</i><br>Due to (or as a consequence of):<br><br><i>Hepatic cancer</i><br>Due to (or as a consequence of):<br><br><i>Renal failure</i><br>Due to (or as a consequence of): |  |   |  |
|   | 23c. <i>4 days</i>   |  |   |  | 23d. <i>Unknown</i>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                       |  | 29b. Signature and title of certifier<br><i>[Signature] (INTERN)</i>  |  | 29c. License number<br><i>P10225</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>April 17, 1997</i>  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>Marcia A. Cort 10 - N. Greene Street, Baltimore MD 21201</i>  |  |   |  | 31. Date filed (Month, Day, Year)<br><i>APR 29 1997</i>   |  |   |  |
|   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |  | 33. Registrar's Title<br><i>[Signature]</i>   |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12934

## Certificate of Death

Reg. No.

|  |   |   |   |                                      |  |  |   |  |   |  |   |  |   |                |  |  |  |
|--|---|---|---|--------------------------------------|--|--|---|--|---|--|---|--|---|----------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Gertrude Jackson</u>   |   |   |                                      | 2. Date of Death<br>Month <u>April</u> Day <u>26</u> Year <u>1997</u>  |  | 3. Time of Death<br><u>3:25 PM</u>  |  |   |  |   |  |   |                |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Lorien Frankford</u>   |   |   |                                      | 4b. City, Town, or Location of Death<br><u>Baltimore</u>   |  | 4c. County of Death<br><u>Baltimore City</u>  |  |   |  |   |  |   |                |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>216-30-5579</u>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>77</u> Yrs.  | If Under 1 Year<br>Months            | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><u>July 25, 1919</u>   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>   |  |   |  |   |  |   |                |  |  |  |
|  | Usual Residence of Decedent   |   |   |                                      |  |  |   |  |   |  |   |  |   |                |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><u>Maryland</u>   | 10b. County<br><u>NA</u>  | 10c. City, Town or Location<br><u>BALTIMORE</u>   |                                      |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |  |   |  |   |                |  |  |  |
|  | 10a. Street and Number<br><u>3915 Calloway Avenue</u>   |   | 10f. Zip Code<br><u>21215</u>   |                                      | 10g. Citizen of What Country?<br><u>USA</u>  |  |   |  |   |  |   |  |   |                |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>   |  |   |  |   |  |   |                |  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br><u>9th grade</u>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><u>DOMESTIC</u>                   |                                      | 16b. Kind of Business/Industry<br><u>Private family</u>  |  |   |  |   |  |   |  |   |                |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><u>William Adams</u>   |   |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Theresa Beckett</u>  |  |   |  |   |  |   |  |   |                |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><u>JAMES JACKSON / Husband</u>  |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3915 Calloway Avenue #412 Baltimore Maryland 21215</u>                                   |  |   |  |   |  |   |  |   |                |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Pleasant Rest Cemetery</u>   |                                      | 20c. Location - City or Town, State<br><u>Towson, Maryland</u>   |  | 20d. Date<br><u>5/1/97</u>  |  |   |  |   |  |   |                |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>   |   | 22. Name and Address of Facility<br><u>CHATTAM - HARRIS F. N. 5240 Reisterstown Road Baltimore, Maryland 21215</u>                                |                                      |  |  |   |  |   |  |   |  |   |                |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |                                      |  |  |   |  |   |  |   |  |   |                |  |  |  |
|  | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Septic Shock</u><br/>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death<br/><u>1 week</u></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <u>metastatic Adenocarcinoma</u><br/>Due to (or as a consequence of):</td> <td><u>1 month</u></td> </tr> <tr> <td>c. <br/>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. <br/>Due to (or as a consequence of):</td> <td></td> </tr> </table> |   |   |                                      |  |  |   |  | Immediate Cause (Final disease or condition resulting in death) | a. <u>Septic Shock</u><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><u>1 week</u> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <u>metastatic Adenocarcinoma</u><br>Due to (or as a consequence of): | <u>1 month</u> | c.<br>Due to (or as a consequence of): |  | d.<br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)  | a. <u>Septic Shock</u><br>Due to (or as a consequence of):  | Approximate Interval Between Onset and Death<br><u>1 week</u>   |   |                                      |  |  |   |  |   |  |   |  |   |                |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. <u>metastatic Adenocarcinoma</u><br>Due to (or as a consequence of):   | <u>1 month</u>  |   |                                      |  |  |   |  |   |  |   |  |   |                |  |  |  |
|  | c.<br>Due to (or as a consequence of):  |   |   |                                      |  |  |   |  |   |  |   |  |   |                |  |  |  |
|  | d.<br>Due to (or as a consequence of):  |   |   |                                      |  |  |   |  |   |  |   |  |   |                |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |                                      |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |   |  |   |                |  |  |  |
|  |   |   |   |                                      |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |   |                |  |  |  |
|  |   |   |   |                                      |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |  |   |  |   |                |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                      |  |  |   |  |   |  |   |  |   |                |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M             |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |   |                |  |  |  |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred    |  |  |   |  |   |  |   |  |   |                |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><u>Thomas A. Russi MD</u>  |   | 29c. License number<br><u>D50785</u> |  | 29d. Date signed (Month, Day, Year)<br><u>April 27, 1997</u>   |   |  |   |  |   |  |   |                |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>10805 Hickory Ridge Rd Columbia MD</u>  |   |   |   |                                      |  |  |   |  |   |  |   |  |   |                |  |  |  |
| 31. Date filed (Month, Day, Year)<br><u>APR 29 1997</u>  |   | 32. Registrar's Signature<br><u>John Davidson-Randall</u>   |   |                                      |  |  |   |  |   |  |   |  |   |                |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and immediately filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12935

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Theresa E. Koubek

2. Date of Death

Month April Day 25, Year 1997

3. Time of Death

8:35 PM

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare-Hamilton Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-22-5375

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Nov. Day 12, Year 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

732 N. Linwood Ave.

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Kolarik

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Cibulka

19a. Informant's Name/Relationship (Type, Print)

Joseph F. Koubek (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1624 Ingram Rd., Baltimore, MD 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gardens of Faith Cem.

Date

4/29/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home  
3331 Brehms Lane, Baltimore, MD 2121323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Urinary Tract Infection

Due to (or as a consequence of):

b.

Chronic Renal Failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard H Bond MD 9615 Belair Road Baltimore MD 21236

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

J. Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: All death certificates have been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12936

## Certificate of Death

Reg. No.

|   |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Edmund F. Kwiatkowski</b>   |  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>22</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>1:00 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Woods Nursing Center</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>168-18-1064</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 27, 1922</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Bel Air</b>   |  |
| To Be Completed by Funeral Director                                       | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>203 D. Fairwood Road</b>  |  | 10f. Zip Code<br><b>21014</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner                             | 15. Decedent's Education (Specify only highest grade completed)<br><b>7th grade</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Wire Machinist</b>   |  | 16b. Kind of Business/Industry<br><b>Manufacturing</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Sylvester Kwiatkowski</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Stefania Maslowski</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Judy Fell (daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>57 Samuel Chase Drive, Port Deposit, MD 21094</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| Physician<br>/Medical<br>Examiner   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Homes, Inc.<br/>9705 Belair Rd., Baltimore, MD 21236</b>   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>METASTATIC LUNG CANCER - NON SMALL CELL TYPE</b><br>Due to (or as a consequence of):<br><br>b. <b>ATRIAL FIBRILLATION</b><br>Due to (or as a consequence of):<br><br>c. <b>ANEMIA</b><br>Due to (or as a consequence of):<br><br>d. <b>CHRONIC RENAL INSUFFICIENCY</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEPRESSION</b>  |  |  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |   |  |
| State Registrar   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>M. Unni ATTENDING</b>   |  |
| To Be Completed by Physician/Medical Examiner                             | 29c. License number<br><b>D51090</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>04/23/97</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. UNNI, MD FRANKLIN WOODS, FRANKLIN SQ DR, BALTIMORE MD</b>  |  | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  |
|   | 32. Registrar's Signature<br>   |  | 33. Registrar's Stamp<br><b>21237</b>  |  |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a-f per MEO G-747 5/1/97 <sup>reb</sup> Certificate of Death

Reg. No.

97 12937

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>KEVIN WOOD KOLL</b>  |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>21</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>11:22AM</b>   |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>706 MASON ROAD</b>   |   | 4b. City, Town, or Location of Death<br><b>STEVENSVILLE</b>  |  | 4c. County of Death<br><b>QUEEN ANNE'S</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>399-48-8128</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                  | 7. Age (In yrs. last birthday)<br><b>41</b> Yrs.   | If Under 1 Year<br>Months Days                               | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>July 8, 1955</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Wisc.</b>   |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   |  |  |  |
|  | 10e. State<br><b>Md.</b>  | 10b. County<br><b>Queen Anne's</b>  | 10c. City, Town or Location<br><b>Stevensville</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>706 Mason Road</b>   |   | 10f. Zip Code<br><b>21666</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>              |  |  |
|  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Painter</b>  |   | 16b. Kind of Business/Industry<br><b>Self-Employed</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Thomas James Koll</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pelchie T. Sobotta</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas J. Koll (Father)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12221 Rios Rd., DanDiego, Calif. 92128</b>     |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Cremation Center Stevensville, Md.</b>                     |  | 20c. Location - City or Town, State<br><b>Stevensville, Md.</b>  |
|  | 21. Signature of Funeral Service Licensee<br><i>Chad M. Helfenbein</i>  |   | 22. Name and Address of Facility<br><b>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A.<br/>106 Shamrock Rd., Chester, Md. 21619</b>            |  |  |
| Physician<br>/Medical<br>Examiner  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |   |  |  |  |
|  | Immediate Cause (Final disease or condition resulting in death)   |   |  |  |  |
|  | a. <b>NARCOTIC INTOXICATION</b>   |   |  |  |  |
|  | Due to (or as a consequence of):  |   |  |  |  |
|  | b. Due to (or as a consequence of):   |   |  |  |  |
|  | c. Due to (or as a consequence of):   |   |  |  |  |
|  | d. Due to (or as a consequence of):   |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                      |   |  |  |  |
|  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>found 4/21/97</b>                              |  |  |  |
| 28b. Time of Injury<br><b>8:00</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>Unknown</b>          |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>found: residence</b>  |   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Stevensville, Maryland</b>  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Monique Dore Chell</i>   |   | 29c. License number<br><b>O.C.M.E</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 22, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARYSANDRA P. KOLLER 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12938

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN KRIEG

2. Date of Death  
Month Day Year

APRIL 20, 1997

3. Time of Death

7:20 AM

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MARYLAND BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

214-01-5686

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Sept. 16, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1312 Warwick Drive

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1929-1933

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Self-Employed

16b. Kind of Business/Industry

Rigging &amp; Hauling

17. Father's Name (First, Middle, Last)

John A. Krieg

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Mitchell

19e. Informant's Name/Relationship (Type, Print)

Mrs. Grace E. Krieg Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1312 Warwick Drive Lutherville, Maryland 21093

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cemetery 4/23/97

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1050 York Road  
Ruck Towson Funeral Home, Inc. Towson, Md. 21204

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MYELODYSPLASIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28e. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 30263

29d. Date signed (Month, Day, Year)

4-22-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204

State  
Registrar

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12939

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VERONICA CAROLINE KUSIAK

2. Date of Death

APRIL 22 1997

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE City

Funeral  
Director

5. Social Security Number

181 05 1621

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 13, 1920

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5719 Moore Street

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Inspector

16b. Kind of Business/Industry

A.T. &amp; T.

17. Father's Name (First, Middle, Last)

Julian Yastremski

18. Mother's Name (First, Middle, Maiden Surname)

Anna Buschta

19a. Informant's Name/Relationship (Type, Print)

Clement Kusiak / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6302 Homewood Road Linthicum, Maryland 21090

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park

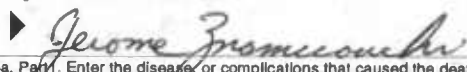
Date

4/26/97

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

METASTATIC BILIARY CANCER

Approximate Interval Between Onset and Death

4 MONTHS

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NIL

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accidental3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

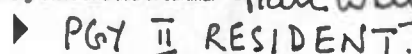
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

  
PGY II RESIDENT.

29c. License number

\*AS2441614-42

29d. Date signed (Month, Day, Year)

APRIL 22 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAN WIN TUN, HARBOR HOSPITAL CENTER.

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

to the Registrar of Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

In the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

25



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12940

## Certificate of Death

Reg. No.

|  |  |   |  |   |   |                                 |   |  |   |  |
|--|--|---|--|---|---|---------------------------------|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Patricia Mary LINGELBACH</b>                              |   |  |   | 2. Date of Death<br>Month Day Year<br><b>April 25, 1997</b> |                                 |   |  | 3. Time of Death<br><b>3:25 P.M.</b>                  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>     |                                 |   |  | 4c. County of Death<br><b>Baltimore</b>               |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-28-7547</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.            |                                 | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 9, 1932</b> |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |  |
|  | Usual Residence of Decedent  |   |  |   |   |                                 |   |  |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore City</b>  |   |                                 |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b># 10 Seagate Court</b>  |  |   |  | 10f. Zip Code<br><b>21221</b>   |   |                                 |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |                                 |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3rd Grade</b><br>College (1-4or 5+) <b>N/A</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   |                                 |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Daniel V. Maskell, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Gray</b>  |   |                                 |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert C. Lingelbach/Husband</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>#10 Seagate Court Baltimore Maryland 21221</b>  |   |                                 |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Cem.</b>   |   | Date<br><b>April 29, 1997</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore MD</b>                                     |   |  |
| 21. Signature of Funeral Service Director<br>  |  |   |  | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home, Inc.<br/>1501 E. Fort Avenue, Baltimore, MD 21230</b>   |   |                                 |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) a. <b>SEPSIS</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last {<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |   |   |                                 |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEHYDRATION, SEVERE LIVER CIRRHOSIS</b>   |  |   |  |   |   |                                 |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |   |                                 |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |   |                                 |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |   |   |                                 |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                 |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b> |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   |  |
|  |  |   |  | 28d. Describe how Injury occurred   |   |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br>  |   |                                 |   | 29c. License number<br><b>023967</b>   |   |  |
|  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>4-28-97</b>   |   |                                 |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BESSE G-GAMMA, MD 3440 BELAIR RD BALTIMORE MD 21206</b>   |  |   |  |   |   |                                 |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |  |   |  | 32. Registrar's Signature<br>  |   |                                 |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours of death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12941

|   |   |  |   |  |   |  |  |  |   |
|---|---|--|---|--|---|--|--|--|---|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><u>Walter Lokeman</u>   |  |   |  |   | 2. Date of Death<br>Month <u>April</u> Day <u>21</u> Year <u>1997</u>  |  | 3. Time of Death<br><u>2:42 AM</u>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Liberty Medical Center</u>   |  |   |  |   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>   |  | 4c. County of Death<br><u>Baltimore</u>  |   |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><u>217-16-1289</u>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>77</u> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><u>SEPT. 25, 1919</u>   |  | 9. Birthplace (State or Foreign Country)<br><u>MARYLAND</u> |
|   | Usual Residence of Decedent   |  |   |  |   |  |  |  |   |
| <b>To Be Completed by Funeral Director</b>  | 10a. State<br><u>MARYLAND</u>   |  | 10b. County<br><u>N/A</u>   |  | 10c. City, Town or Location<br><u>BALTIMORE CITY</u>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|   | 10e. Street and Number<br><u>1734 E. 25<sup>th</sup> STREET</u>   |  |   |  | 10f. Zip Code<br><u>21213</u>   |  | 10g. Citizen of What Country?<br><u>USA</u>  |  |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>6-5-43</u><br>If Yes, Give Year or Dates: <u>2-13-46</u>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>8<sup>th</sup> GRADE</u> College (1-4 or 5+)  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>MAIL HANDLER</u> |   |  | 16b. Kind of Business/Industry<br><u>U.S. POSTAL SERVICE</u>   |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><u>CLARENCE LOKEMAN</u>  |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>EDNA WARD</u>  |  |  |   |
| <b>To Be Completed by Physician/Medical Examiner</b>  | 19a. Informant's Name/Relationship (Type, Print)<br><u>EVA WALTERS (SISTER)</u>   |  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1734 E. 25<sup>th</sup> STREET, BALTIMORE, MD. 21213</u> |  |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>GARRISON FOREST</u>  |  | Date<br><u>4-25-97</u>  |  | 20c. Location - City or Town, State<br><u>OWINGS MILLS, MD.</u>  |  |   |
|   | 21. Signature of Funeral Service Licensee<br><u>J. Brown</u>  |  |   |  |   | 22. Name and Address of Facility<br><u>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>2140 N. FULTON AVE., BALTIMORE, MD. 21217</u>                              |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |  |  |   |
|   | <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Pulmonary Edema</u></p> <p>Due to (or as a consequence of):</p> <p>b. _____</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> |  |   |  |   |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|   |   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><u>M</u>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                           |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |   |  |  |  |   |
| 29b. Signature and title of certifier<br><u>Lawrence MD</u>   |   |  |   |  | 29c. License number<br><u>D33588</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>April 21, 1997</u>   |  |   |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br><u>Tony Lawrence MD - Liberty Medical Center</u>  |   |  |   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><u>APR 29 1997</u>   |   |  | 32. Registrar's Signature<br><u>John Davidson-Randall</u>   |  |   |  |  |  |   |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12942

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>EUGENE SR. LEE</b>   |  |   |  | 2. Date of Death<br>Month <b>4</b> Day <b>26</b> Year <b>97</b>   |  | 3. Time of Death<br><b>3:14AM</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>BON SECOURS HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>MD</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-36-6877</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 18, 1939</b>                                |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>None</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>41 N. Catherine St.</b>  |  | 10f. Zip Code<br><b>21223</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Auto Technician</b>               |  | 16b. Kind of Business/Industry<br><b>Chevy Plant</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Eugene Lee Sr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lue Ester Julius</b>  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mozell Wilson / Sister</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1114 Wicklow Rd. Baltimore, Maryland 21229</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill</b>   |  | 20c. Location - City or Town, State<br><b>4-30-97 Glen Burnie, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br>   |  |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility<br><b>The Derrick C. Jones Funeral Home</b><br><b>4611 Park Heights Ave. Baltimore, Maryland 21215</b>   |  |   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPSIS</b><br>Due to (or as a consequence of):<br><b>MULTIPLE INTRA-ABDOMINAL ABSCESES</b><br>Due to (or as a consequence of):<br><b>AIDS</b><br>Due to (or as a consequence of):                         |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year)   |  |   |  | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |
|   | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D-24710</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-26-97</b>                                       |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARMANDO A. REAL, MD</b>  |  |   |  | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  |   |  |
|   | 32. Registrar's Signature<br>   |  |   |  | 33. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BON SECOURS HOSPITAL</b><br><b>2000 WEST BALTIMORE, MD 21223</b>   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

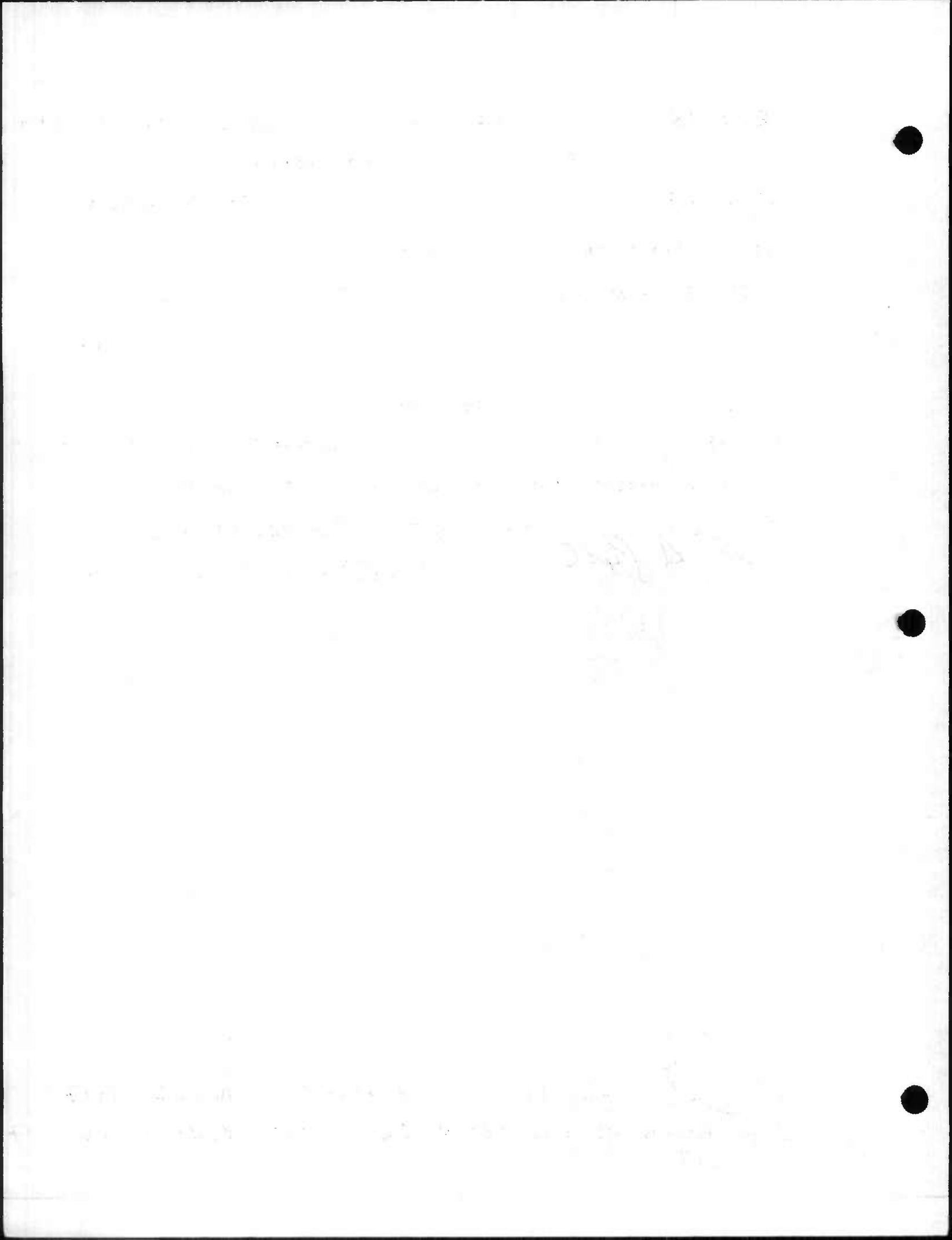
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12943

|  |   |   |   |  |  |  |  |   |  |
|--|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EVELYN V. LLOYD</b>  |   |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>26</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>2:42 PM</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death<br><b>N/A</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-12-3791</b>   |   | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>AUG 13, 1917</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Arbutus</b>    |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>5111 Arbutus Avenue</b>  |   |   |  | 10f. Zip Code<br><b>21227</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>College</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John Albert Carter</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Theresa Elizabeth Willinger</b>  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret M. Lynch/sister</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5111 Arbutus Ave. Arbutus, MD 21227</b>  |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>  |  | 20c. Date<br><b>4/30/97</b>  |  | 20d. Location - City or Town, State<br><b>Elkridge, MD</b>                                     |   |  |
|  | 21. Signature of Funeral Service Licensee<br><br><b>Edward A. Gregorchik</b>  |   | 22. Name and Address of Facility<br><b>MacNabb Funeral Home, P.A.<br/>301 Frederick Rd. Baltimore, MD 21228</b>                                   |  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CORONARY ARTERY BYPASS GRAFT</b><br>Due to (or as a consequence of):<br><b>b. CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |  |  |   |  |
|  | 23b. Approximate Interval Between Onset and Death<br><b>5 days</b><br><b>YEARS</b>  |   |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|  |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury<br>(Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                           |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><br><b>John P. Wolfe</b>   |   |   |   | 29c. License number<br><b>RES-000</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 26, 1997</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHNS HOPKINS HOSPITAL 600 N. WOLFE STREET BALTIMORE MD 21287</b>   |   |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |   |   |   |  |  |  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12944

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES LANGENWALTER</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 23, 1997</b>   |  | 3. Time of Death<br><b>19:22</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Agnes Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>                                       |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>500-32-8556</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JAN 03, 1928</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Ellicott City</b>                     |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3714 Lookout Court</b>  |  | 10f. Zip Code<br><b>21042</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1951-53</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Program Manager</b>                              |  | 16b. Kind of Business/Industry<br><b>Defense Technology Contractor</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Leroy S. Langenwalter</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Stella V. Bonham</b>  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jane M. Langenwalter/wife</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3714 Lookout Ct. Ellicott City, MD 21042</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 4/25/97</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |  | 21. Signature of Funeral Service Licensee<br><b>George E. MacNabb</b>   |  |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>   |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Atherosclerotic coronary vessel disease 2 years</b><br>Due to (or as a consequence of):<br><b>b. Hypertension 10 years</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28b. Time of Injury<br>M  |  |   |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br><b>Physician</b>   |  |   |  |
|   | 29c. License number<br><b>DS0708</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>April 23<sup>rd</sup>, 1997</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>900 South Caton Avenue Baltimore, Maryland</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  |   |  |
|   | 32. Registrar's Signature<br><b>John Davidson-Randall</b>  |  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 12945

## Certificate of Death

Reg. No.

|   |  |   |   |   |   |  |   |  |
|---|--|---|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Erford Loudermilk</b>   |   |   |   | 2. Date of Death<br>Month <b>April</b> Day <b>25</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>5:30 pm</b>  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Liberty Medical Center</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>245-38-8038</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>April 6, 1917</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Georgia</b>   |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Dundalk</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>8106 Eleanor Terrace</b>   |   | 10f. Zip Code<br><b>21222</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1 Year</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Fork Lift Operator</b>  |   | 16b. Kind of Business/Industry<br><b>Fence Company</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Herbert Loudermilk</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lula Crow</b>   |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Paulette Porter/Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1415 Misty Creek Ct. Orlando, Florida 32824</b> |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakeview Cemetery</b>  |   | 20c. Date<br><b>4/29/1997</b>   |  | 20d. Location - City or Town, State<br><b>Sykesville, MD</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Charles W. Ford</b>  |   | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>sepsis</b><br>Due to (or as a consequence of):<br><b>Dehydration</b><br>Due to (or as a consequence of):<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Hypertension</b><br><b>Dementia</b> |  | Approximate Interval Between Onset and Death<br><b>unknown</b><br><b>unknown</b>  |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Dementia</b>  |   | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>April 25, 1997</b>   |  |
|   | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>John H. Zrebeck, M.D.</b>   |   | 29c. License number<br><b>D33583</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>April 25, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>John H. Zrebeck, M.D.</b><br><b>2600 Liberty Heights Ave Baltimore, MD 21295</b> |  | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b> |   | 32. Registrar's Signature<br><b>John H. Zrebeck</b> |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12946

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital & Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |                                |  |  |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Sarah Lee</b>   |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>28</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>12:50 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Mercy Medical Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>213-14-9553</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 12, 1918</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |  |  |                                |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>524 NORTH CHARLES ST.</b>   |  |   |  | 10f. Zip Code<br><b>21201</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 YRS</b><br>College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>  |                                | 16b. Kind of Business/Industry<br><b>HOMEMAKER</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>WILLIAM G. KERBIN</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ALICE BOEHM</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS SARAH L. WINTER (DAUGH)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8 HOLLY BERRY CT. GLEN ARM, MD. 21057.</b>   |                                |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OLD ST. PAULS (NICHE)</b>  |  | Date<br><b>5-1-97</b>  |                                | 20c. Location - City or Town, State<br><b>BALTO., MD.</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>HENRY W. JENKINS &amp; SONS CO.<br/>4905 YORK RD. BALTO., MD. 21212.</b>  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. cerebro vascular Accident</b><br>Due to (or as a consequence of):<br><b>b. Atrial Fibrillation</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Due to (or as a consequence of): |  |   |  |  |                                | Approximate Interval Between Onset and Death<br><b>7 days</b><br><b>5 years</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D0050853</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>April 28, 1997</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vijay Pethkar 301 St. Paul Place, Baltimore MD 21202.</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |  |   |  | 32. Registrar's Signature<br>   |                                |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12947

|  |   |   |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|--|---|---|---|---|---|---|---|--|---|-------------------------------------|----------------------------------|--|--|------------------|--|--|-------------------------------------|------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Lauren B. Lendle</b>   |   |   |   | 2. Date of Death<br>Month <b>April</b> Day <b>21</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>1222</b>   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Hospital</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |   | 4c. County of Death<br><b>N/A</b>                                       |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212 23 3652</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>13</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 3, 1984</b>              |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>                         |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>4110 Fairhaven Avenue</b>  |   | 10f. Zip Code<br><b>21226</b>   |   | 10g. Citizen of What Country?<br><b>U.S.</b>                            |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>                       |   | 16b. Kind of Business/Industry<br><b>School</b>   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Donald Lendle</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Joan Gair</b>   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan Stull / mother</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4110 Fairhaven Avenue Baltimore, Maryland 21226</b>                                       |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>4/25/97 Baltimore, Maryland</b>   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Jerome Brumfield</b>  |   |   |   | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>  |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td rowspan="4">e. Due to (or as a consequence of):</td> <td colspan="2"><b>Respiratory Insufficiency</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>1 day</b></td> </tr> <tr> <td colspan="2"><b>pneumonia</b></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td rowspan="2">f. Due to (or as a consequence of):</td> <td colspan="2"><b>Cystic fibrosis</b></td> </tr> <tr> <td colspan="2"></td> </tr> </table> |   |   |   |   |   |   |  | Immediate Cause (Final disease or condition resulting in death) | e. Due to (or as a consequence of): | <b>Respiratory Insufficiency</b> |  | Approximate Interval Between Onset and Death<br><b>1 day</b> | <b>pneumonia</b> |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | f. Due to (or as a consequence of): | <b>Cystic fibrosis</b> |  |  |  |
|  | Immediate Cause (Final disease or condition resulting in death)   | e. Due to (or as a consequence of):   | <b>Respiratory Insufficiency</b>  |   | Approximate Interval Between Onset and Death<br><b>1 day</b>  |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| <b>pneumonia</b>   |   |   |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   | f. Due to (or as a consequence of):   | <b>Cystic fibrosis</b>                                    |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  |   |   |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b>   |   |   |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                           |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  |   | 28d. Describe how injury occurred   |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)      |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
|  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| 29b. Signature and title of certifier<br><b>Laura Hastings MD</b>  |   |   |   | 29c. License number<br><b>D50071</b>                      |   | 29d. Date signed (Month, Day, Year)<br><b>April 21, 1997</b>                                |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Laura Hastings, MD The Johns Hopkins Hospital, Baltimore, MD</b>  |   |   |   |   |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |   |   |   | 32. Registrar's Signature<br><b>John Davidson-Randall</b> |   |   |   |  |   |                                     |                                  |  |  |                  |  |  |                                     |                        |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

4



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State of Maryland / Department of Health and Mental Hygiene 97 12948

Certificate of Death

Reg. No.

|  |  |  |   |   |  |   |  |   |  |  |
|--|--|--|---|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ODESSA MARSHALL  |  |   |   | 2. Date of Death<br>Month Day Year<br>APRIL 24 1997  |   | 3. Time of Death<br>10:00 P.M.   |   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>BON SECOUR HOSPITAL  |  |   |   | 4b. City, Town, or Location of Death<br>BALTIMORE  |   | 4c. County of Death<br>N/A   |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>249-46-5234   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>71 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Month, Day, Year<br>Jan. 3, 1926  |  | 9. Birthplace (State or Foreign Country)<br>South Carolina  |  |  |
|  | Usual Residence of Decedent  |  |   |   |  |   |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   | 10b. County<br>N/A   | 10c. City, Town or Location<br>Baltimore  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |  |   |  |  |
|  | 10e. Street and Number<br>812 N. Carey St.   |  |   | 10f. Zip Code<br>21217  |  | 10g. Citizen of What Country?<br>USA  |  |   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: African American  |   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Meat Processor   |  | 16b. Kind of Business/Industry<br>Mash's Ham Co.  |  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Walter M. Hancock   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Helen Davis   |   |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Wendell Marshall (Son)   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7022 Yataruba Drive Balto. Md. 21207  |   |  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Zion  |   | 20c. Location - City or Town, State<br>5/2/97 Lansdowne, Md.   |   |  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Joseph L. Russ  |  |   |   | 22. Name and Address of Facility<br>Joseph L. Russ Funeral Home<br>2222 W. North Ave. Balto. Md. 21216   |   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>a. _____<br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |   |  |   |  |   | Approximate Interval Between Onset and Death |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |  |
|  |  |  |   |   |  | 24a. Was an autopsy performed?<br>INSPECTION<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                    |  | 28d. Describe how injury occurred   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br>[Signature]   |  |  |   | 29c. License number<br>O.C.M.E.   |  | 29d. Date signed (Month, Day, Year)<br>APRIL 25, 1997   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DAVID R. FOWLER MD. 111 Penn Street, Baltimore, Maryland 21201   |  |  |   |   |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1997   |  |  |   | 32. Registrar's Signature<br>[Signature]  |  |   |  |   |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

97 12949

## Certificate of Death

Reg. No.

|   |   |   |   |  |   |  |  |  |  |
|---|---|---|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ARLENE MIMS</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 17, 1997</b> |  | 3. Time of Death<br><b>5:52 PM</b>   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>     |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-70-6410</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F            |  | 7. Age (In yrs. last birthday)<br><b>46</b>                 |  | 8. Date of Birth<br>Month Day Year<br><b>April 3, 1951</b>                                       |  |  |
|   | 9. Birthplace (State or Foreign)<br><b>Washington, DC</b>   |   | 10a. Usual Residence of Decedent<br>10a. Street and Number<br><b>5011 Colburn Terrace</b> |  | 10b. City, Town, or Location<br><b>West Hyattsville</b>     |  | 10c. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>24</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Postal Person</b>   |   | 16b. Kind of Business/Industry<br><b>Government</b>  |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Forchen Miller</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hattie Mae Harris</b>  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Forchen Miller, Jr. Brother</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>505 Suffolk Ave. #215; Capitol Heights, MD 20743</b>   |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery or crematory or other place)<br><b>Parklawn Cemetery</b>  |   | 20c. Date<br><b>4/24/97</b>  |   | 20d. Location - City or Town, State<br><b>Rockville, MD</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br><b>Bianchi Funeral Service<br/>3718 22nd Street NE; Washington, DC 20018-3004</b>  |   |  |  |  |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Atherosclerotic Cardiovascular disease</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |   |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
|   |   |   |   |  |   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
|   |   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
|   |   | 28d. Describe how Injury occurred   |   |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 18, 1997</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>  |   |   |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |   | 32. Registrar's Signature<br>   |   |  |   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12950

## Certificate of Death

Reg. No.

|  |   |                              |   |   |  |  |   |  |   |  |  |
|--|---|------------------------------|---|---|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Daniel M. Malkin</u>                                     |                              |   |   |  |  | 2. Date of Death<br>Month <u>April</u> Day <u>24</u> Year <u>1997</u> |  | 3. Time of Death<br><u>8:20 AM</u>                                      |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Howard County General Hospital</u> |                              |   |   |  |  | 4b. City, Town, or Location of Death<br><u>Columbia</u>               |  | 4c. County of Death<br><u>Howard</u>                                    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>551-43-2644</u>   |                              | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><u>33</u> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><u>June 29, 1963</u>           |  | 9. Birthplace (State or Foreign Country)<br><u>California</u>           |  |  |
|  | Usual Residence of Decedent   |                              |   |   |  |  |   |  |   |  |  |
| 10a. State<br><u>MD</u>  |   | 10b. County<br><u>Howard</u> |   | 10c. City, Town or Location<br><u>Columbia</u>  |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 10e. Street and Number<br><u>7336 Kindler Road</u>   |   |                              |   | 10f. Zip Code<br><u>21046</u>   |  |  |   | 10g. Citizen of What Country?<br><u>USA</u>  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>5+</u> College (1-4 or 5+) <u>5+</u>   |   |                              |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Professional Musician</u>   |  |  |   | 16b. Kind of Business/Industry<br><u>Symphonic Orchestra</u>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>Richard Malkin</u>   |   |                              |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Carole B. Jacobs</u>   |   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Wonju Kim Malkin/wife</u>   |   |                              |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7336 Kindler Rd. Columbia, MD 21046</u>  |   |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                              |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Metro Crematory, Inc.</u>  |  | Date<br><u>4/25/97</u>   |   | 20c. Location - City or Town, State<br><u>Baltimore, MD</u>  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><u>Edward A. Gregorchik</u>   |   |                              |   |   |  | 22. Name and Address of Facility<br><u>Cremation Society of Maryland, Inc.</u><br><u>299 Frederick Rd. Baltimore, MD 21228</u>   |   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>a. Respiratory Failure</u><br>Due to (or as a consequence of):<br><u>b. Melanoma - metastatic</u><br>Due to (or as a consequence of):<br><u>c.</u><br>Due to (or as a consequence of):<br><u>d.</u><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                              |   |   |  |  |   |  |   | Approximate Interval Between Onset and Death<br><u>1 year.</u> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Anemia, left arm pain.</u><br><u>Anorexia - Cachexia Syndrome.</u>  |   |                              |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                              |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |                              |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><u>M</u>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred                              |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                              |   | 29b. Signature and title of certifier<br><u>Jon K. Munsel</u>   |  |  |   | 29c. License number<br><u>D 30573</u>  |   | 29d. Date signed (Month, Day, Year)<br><u>4-24-97</u>          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Jon K. Munsel, MD 11065 Little Patuxent Parkway Columbia MD 21044</u>   |   |                              |   |   |  |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>APR 29 1997</u>  |   |                              |   | 32. Registrar's Signature<br><u>Julia [Signature]</u>   |  |  |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12951

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

TERRELL

MILBURN

2. Date of Death

Month Day Year  
APRIL 25, 1997

3. Time of Death

00:17 AM

4a. Facility Name (If not Institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-98-4983

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

26

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 22, 1970

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5611 Haddon Ave.

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

City Worker

16b. Kind of Business/Industry

Baltimore City Dept  
Of Works

17. Father's Name (First, Middle, Last)

Dwight Milburn

18. Mother's Name (First, Middle, Maiden Surname)

Mary Faulk

19a. Informant's Name/Relationship (Type, Print)

Mary Milburn- Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5600 Burtis Ave. Baltimore, Maryland 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Zion Cemetery

Date

4-29-97

20c. Location - City or Town, State

Lansdowne, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CAPLE FUNERAL SERVICE.

5502 Winner Ave. Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Gunshot wounds to chest and left arm.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☒ Homicide

28a. Date of Injury

(Month, Day, Year)

4-24-97

28b. Time of

Injury

23:40M

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject shot

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

35 W Belvedere

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

APRIL 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R. Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Lisa Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 72 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12952

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

KATHERINE MARSHALL

2. Date of Death

Month

Day

Year

APRIL 22 1997

3. Time of Death

6:05 PM

4a. Facility Name (If not institution, give street and number)

St. Elizabeth Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

180 03 6190

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 1, 1902

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3320 Benson Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

not available

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Drugstore

17. Father's Name (First, Middle, Last)

William Smith

18. Mother's Name (First, Middle, Maiden Surname)

Mary Geltz

19a. Informant's Name/Relationship (Type, Print)

Kathleen Towles / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

410 Old Riverside Road Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

4/24/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Dana Branciaro

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic cardiac disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic cerebral disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Laura R. Gallagher MD

29c. License number

D01786

29d. Date signed (Month, Day, Year)

April 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAUREN R. GALLAGHER MD, 716 MAIDEN COTTAGE LANE, BAYTON, MD 21228

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

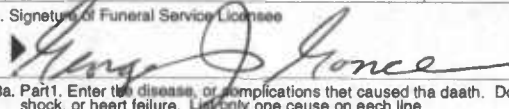




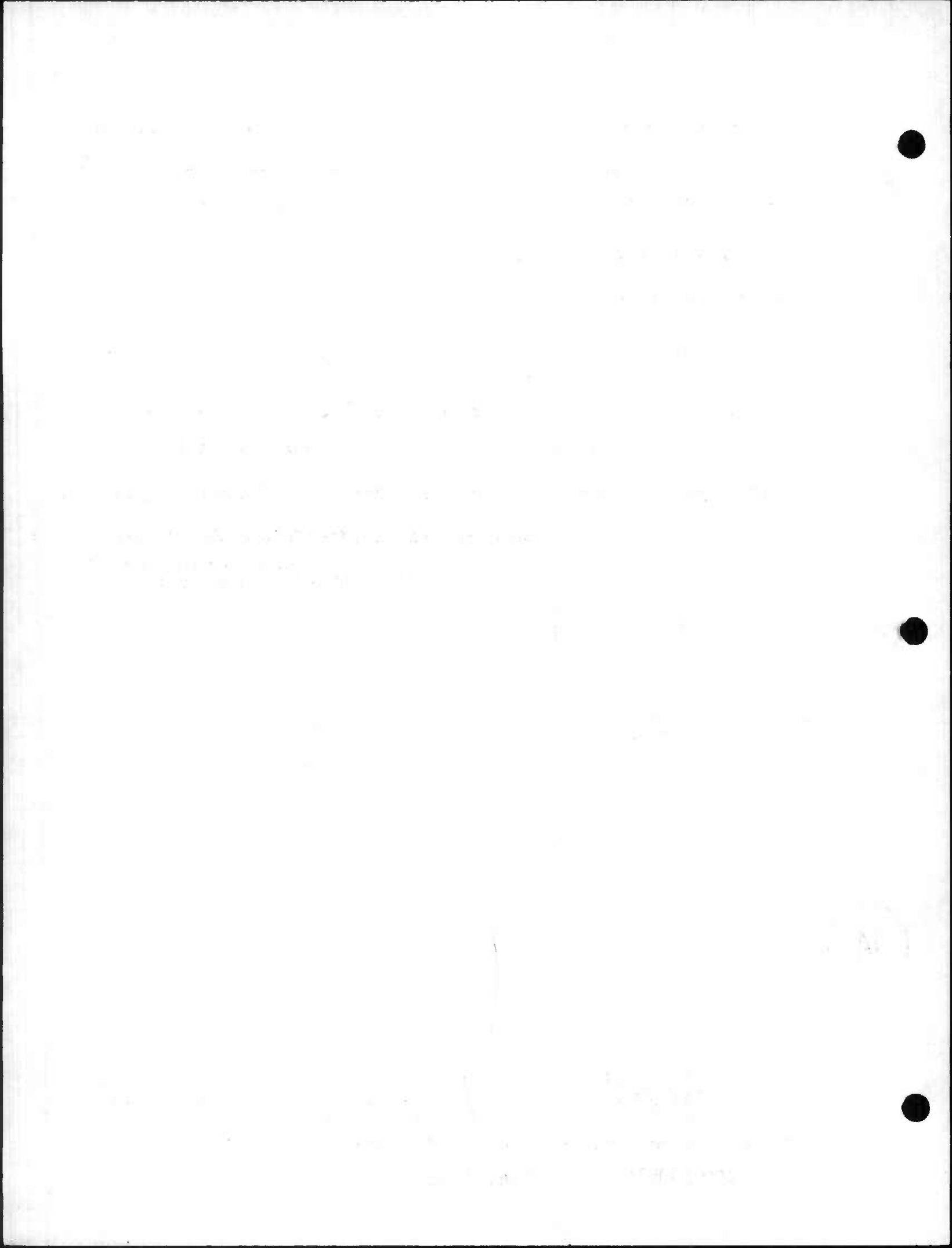
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12953

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Charles H. Meyer</b>  |  |   |  | 2. Date of Death<br>Month <b>04</b> Day <b>24</b> Year <b>97</b>   |  | 3. Time of Death<br><b>0745</b>  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>University of Maryland Medical Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore City</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214 30 3907</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 5, 1933</b>                                     |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| To Be Completed by Funeral Director           | Usual Residence of Decedent<br>10e. State<br><b>Maryland</b>   |  |   |  | 10f. Zip Code<br><b>21225</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b>   |  |
|   | 10b. County<br><b>Anne Arundel</b>   |  |   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance Mechanic</b>          |  | 16b. Kind of Business/Industry<br><b>Domino Sugar</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>John C. Meyer</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Giles</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Donna Meyer / wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>210 W. 11th Avenue Baltimore, Maryland 21225</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>   |  | Date<br><b>4/28/97</b>   |  | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>                            |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>                                  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c. <b>Ventricular Arrhythmias</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  | Approximate Interval Between Onset and Death |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
|   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  |  |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>P10224</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>04-24-97</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Elizabeth Stoller 22 S. Greene Street UMMS Baltimore, MD 21201</b>  |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |  | 32. Registrar's Signature<br>                                  |  |  |  |  |  |





97 12954

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ARTHUR C. MACHOVEC</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 25 1997</b>  |  | 3. TIME OF DEATH<br><b>6:30 A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-46-4283</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 18, 1903</b>                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Church Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH<br><b>N/A</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>N/A</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>                                 |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>5622 Gerland Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21206</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1919-1949</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>10th Grade</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Naval Officer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Anton Unknown Machovec</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary S. Hromadnik</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Doris Derr/Niece</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5622 Gerland Avenue, Baltimore, Maryland 21206</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Most Holy Redeemer Cemetery 4/28/97</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Guanta R. Thomas</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John C. Miller, Inc.<br/>6415 Belair Road, Baltimore, Maryland 21206</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pneumonia</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. <b>pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>A. R. Nazemi, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D17322</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>APRIL 25, 1997</b>                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>A. R. NAZEMI, M.D. CHURCH HOSPITAL, BALTIMORE</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 29 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12955  
Certificate of Death

Reg. No.

|   |   |   |   |  |   |  |  |
|---|---|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Roselie Freburger Nigl</b>                     |   |   | 2. Date of Death<br>Month <b>April</b> Day <b>26</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>12:05 pm</b>  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>4050 Dance Mill Road</b> |   |   | 4b. City, Town, or Location of Death<br><b>Phoenix</b>   |   | 4c. County of Death<br><b>Baltimore Co.</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-05-2644</b>   |   | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>October 31, 1915</b> |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                   |   |   |  |   |  |  |
| Usual Residence of Decedent   |   |   |   |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore Co.</b>   |   | 10c. City, Town or Location<br><b>Phoenix</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>4050 Dance Mill Road</b>   |   |   | 10f. Zip Code<br><b>21131</b>   |  | 10g. Citizen of What Country?<br><b>United States</b> |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b> |  |   | 16b. Kind of Business/Industry<br><b>Home Building Company</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Walter Scott Freburger</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida Hoffmeister</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. John J. Nigl/Husband</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4050 Dance Mill Road Phoenix, Maryland 21131</b>   |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corporation</b>  |   | Date<br><b>4/28/97</b>   |   | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee <b>Brian A. Willem</b><br><b>Brian A. Willem</b>  |   |   |   | 22. Name and Address of Facility <b>Leonard J. Ruck Funeral Home, Inc.</b><br><b>5305 Harford Road Baltimore, Maryland 21214</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Cancer of the lung.</b><br>Due to (or as a consequence of):<br>b. <b>Chronic Obstructive lung disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death |   |   |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   |   |   |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><b>[Signature]</b>   |   | 29c. License number<br><b>D22652</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/28/97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>5601 LOCKRAVEN BLVD BALTIMORE MD 21239.</b>  |   |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12956

|  |  |  |  |  |   |                                 |  |   |  |  |
|--|--|--|--|--|---|---------------------------------|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Patricia Diane Nelson</b>   |  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>26</b> Year <b>1997</b>   |                                 |  |   | 3. Time of Death<br><b>12:45 pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>9 Woody Road</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Essex</b>  |                                 |  |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-58-7536</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>44</b> Yrs.  |                                 | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 10, 1952</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|  | Usual Residence of Decedent<br>10a. State <b>Md.</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>Essex</b> 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>9 Woody Road</b>   |                                 | 10f. Zip Code<br><b>21221</b>                                |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| To Be Completed by Funeral Director  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |                                 |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4 or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Building Manager</b>  |                                 |  |   | 16b. Kind of Business/Industry<br><b>Soc. Sec. Administa.</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>George Loughry</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lorraine Ayres</b>  |                                 |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thyrl F. Nelson</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9 Woody Rd. Essex Md. 21221</b>   |                                 |  |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |  | 20c. Location - City or Town, State<br><b>4-28 Baltimore</b>  |                                 |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Connelly Funeral Home Of Dundalk</b><br><b>7110 Sollers Point Rd. 21222</b> |   |                                 |  |   |  |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>e. <b>OVARIAN CANCER</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. |  |  |  |   |                                 |  |   | Approximate Interval Between Onset and Death<br><b>4 yrs</b>   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |                                 |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |  |  |  |   |                                 |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |  |  |  |   |                                 |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                 |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of injury (Month, Day Year)  |   | 28b. Time of injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|  |  |  |  | 28d. Describe how injury occurred  |   |                                 |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br>  |   |                                 |  | 29c. License number<br><b>D19714</b>  |  |  |
|  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>4/28/97</b>  |   |                                 |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MICHAEL PATELL 548VW 4940 EASTERN AVE BALTIMORE MD 21224</b>  |  |  |  |  |   |                                 |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |  |  |  | 32. Registrar's Signature<br>  |   |                                 |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 12957

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDWARD NOVIN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>April</b> DAY <b>22</b> , 1997 YEAR   |  |  |  | 3. TIME OF DEATH<br><b>1:28 P.</b> M   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>062-24-2817</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>94</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 27, 1902</b>                          |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hebrew Home Of Greater Washington</b>   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>  |  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b> |   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Montgomery</b>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>                                      |  |   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>6121 Montrose Road</b>  |  |  |  | 10f. ZIP CODE<br><b>20852</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>              |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b> College (14 or 5+) <b>Letter Carrier</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Letter Carrier</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Postal Service</b>                         |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Julius Novinsky</b>  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jennie Millstein</b>   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dr. Neil Novin</b>  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8301 Marcie Drive, Baltimore, Maryland 21208</b> |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place)<br><b>Rocktown Memorial Park And Menorah Gardens April 24, 1997</b>  |  |  |  | 20c. LOCATION — City or Town, State<br><b>Rockville, Maryland</b>                    |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald C. Stottumyer</b>   |  |  |  |  |  | 22. NAME AND ADDRESS OF FUNERAL HOME, INC.<br><b>232 CARROLL STREET, N.W. WASHINGTON, D.C. 20012-2095</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MESA SEPSIS</b>   |  |  |  |  |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>MALNUTRITION</b>   |  |  |  |  |  |  |  |  |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPOTHYROIDISM, PROSTATIC HYPERTROPHY</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                           |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Steven Lipson MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 05885</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>04/23/97</b>      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>STEVEN LIPSON 6121 MONTROSE RD. ROCKVILLE</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 29 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Jake Davidson-Randall</b>  |  |  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

JA

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12958

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Theodore Barry Osherooff

2. Date of Death

April 6, 1997

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

5702 - 66th Avenue

4b. City, Town, or Location of Death

East Pines

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

579-54-1541

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 10, 1941

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

East Pines

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5702 - 66th Avenue

10f. Zip Code

20737

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1958-1967

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Electrical Technician

16b. Kind of Business/Industry

Electric

17. Father's Name (First, Middle, Last)

Ben Osherooff

18. Mother's Name (First, Middle, Maiden Surname)

Gussie Rose

19a. Informant's Name/Relationship (Type, Print)

Sharon Kamerow (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13716 Berkeley Road, Silver Spring, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Memorial Gardens

Date

4/7/97

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

Joyce E. Torchinsky

22. Name and Address of Facility

Ives-Pearson Funeral Homes

2847 Wilson Blvd., Arlington, VA 22201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Esophageal Cancer

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1993

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Susan Leggett - Johnson MD

29c. License number

D 38149

29d. Date signed (Month, Day, Year)

April 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Johnson, M.D., 6525 Belcrest Road, Hyattsville, MD 20872

31. Date filed (Month, Day, Year)

APR 29 1997

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

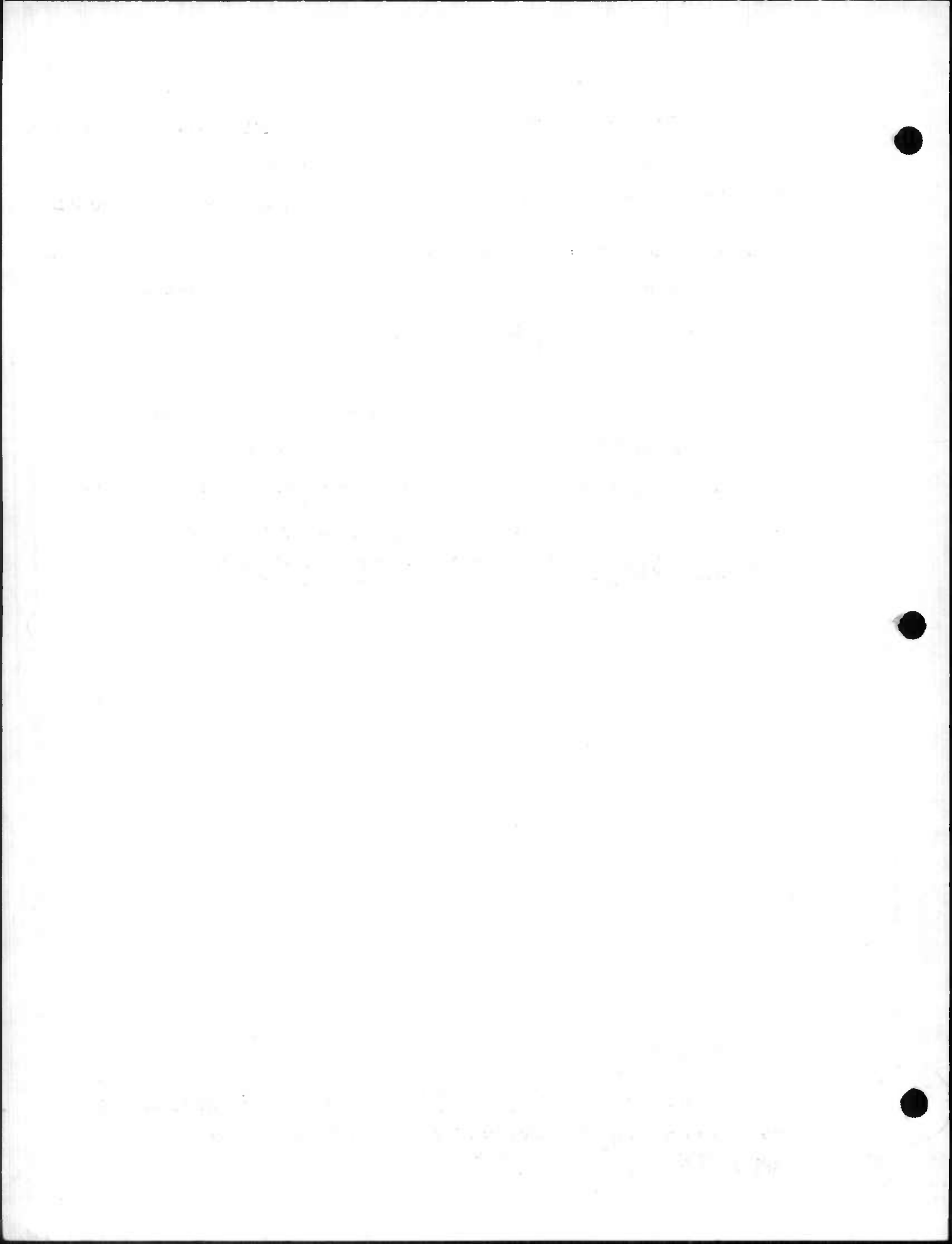
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12959

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Lawrence Parks, Jr.

2. Date of Death

April 25 1997

3. Time of Death

15 30 hrs.

4a. Facility Name (If not institution, give street and number)

3294 York Street

4b. City, Town, or Location of Death

Manchester

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

213-10-1824

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 27, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Manchester

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3294 York Street

10f. Zip Code

21102

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

American Chain &amp; Cable

17. Father's Name (First, Middle, Last)

Richard Lawrence Parks

18. Mother's Name (First, Middle, Maiden Surname)

Annie Nash

19a. Informant's Name/Relationship (Type, Print)

Mae E. Parks - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3294 York St., Manchester, Md. 21102

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory April 26, 1997

Date

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

A. Eckhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel

3296 Charmil Dr., Manchester, Md. 21102

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

SHOTGUN WOUND OF THE HEAD

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?  
inspection1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No

25. Was case referred to medical

examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending2 ☐ Accident 6 ☐ investigation3 ☒ Suicide 6 ☐ Could not be4 ☐ Homicide 6 ☐ determined

28a. Date of Injury

(Month, Day, Year)

4/25/97

28b. Time of

Injury

1400 hrs

28c. Injury at

Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject shot self

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

GARAGE

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

3239 York Street

Manchester, Md.

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Eckhardt

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. Laron Locke, M.D. 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Health Officer or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12960

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |   |   |   |  |
|--|---|---|--|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William Charles Port</b>   |   |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>26</b> , Year <b>1997</b>  |   | 3. Time of Death<br><b>2:00 AM</b>                                      |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>VA MHCS Fort Howard Division</b>   |   |  |  | 4b. City, Town, or Location of Death<br><b>Fort Howard</b>   |   | 4c. County of Death<br><b>Baltimore</b>                                 |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-10-0255</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>4-9-1922</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>   |  |
|  | Usual Residence of Decedent   |   |  |  |  |   |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>n/a</b>   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |   |   |  |
|  | 10e. Street and Number<br><b>128 N. Lakewood Avenue</b>   |   |  |  | 10f. Zip Code<br><b>21224</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Army</b><br>If Yes, Give Year or Dates: <b>2/14/39 to 8/1/45</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>   |  |  | 16b. Kind of Business/Industry<br><b>B &amp; B Auto Supply</b>  |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Nicholas Port</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Brice</b>   |   |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print) <b>son</b><br><b>Darrell Port</b>  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2704 Long Meadow Drive ABingdon, Md. 21009</b> |  |   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forrest Cemetery</b>   |  | Date<br><b>4/29/97</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Co. Maryland</b>   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Maria J. Zannino</i>  |   |  | 22. Name and Address of Facility<br><b>Joseph N. Zannino Jr. Funeral Home</b><br><b>263 S. Conkling Street Baltimore, Maryland 21224</b>           |  |   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Esophageal Cancer</b><br>Due to (or as a consequence of):<br><br>b. <b>Left Lung Mass</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |   |   |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |  |  |  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Pulmonary Disease</b>   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      |   | 28d. Describe how Injury occurred   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D30528</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 26th 1997</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Bala Duggirala, MD 9600 North Point Road, Fort Howard, MD 21052</b>   |   |   |  |  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |   |   |   |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

DDG Item 1,23a,27,28abcdef

State of Maryland / Department of Health and Mental Hygiene

97 12961

• 2r MEO FilmG747 5-6-97 rja

ITYEM#22 PER F.H. FLM#C746 4.29.97 J.A.

## Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) DARRYL ROCHE

2. Date of Death Month Day Year APRIL 28, 1997

3. Time of Death 06:56 AM

4a. Facility Name (If not institution, give street and number) LIBERTY MEDICAL CENTER E.R.

4b. City, Town, or Location of Death BALTIMORE

4c. County of Death n/a

5. Social Security Number 216-74-0412

6. Sex 10X M 20 F

7. Age (In yrs. last birthday) 39 Yrs.

8. Date of Birth Month Day Year JAN. 19, 1958

9. Birthplace (State or Foreign Country) MARYLAND

Usual Residence of Decedent

10e. State MD

10b. County n/a

10c. City, Town or Location BALTIMORE

10d. Inside City Limits 10X Yes 20 No

10e. Street and Number 1600 N. BENTALOU STREET

10f. Zip Code 21216

10g. Citizen of What Country? UNITED STATES

11. Marital Status 10X Never Married 20 Married 30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No 10X Yes 20 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 20 No 10X No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DRAFTING

16b. Kind of Business/Industry HOME IMPROVEMENT

17. Father's Name (First, Middle, Last) RUDOLPH WALKER

18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY ROCHE

19e. Informant's Name/Relationship (Type, Print) SHIRLEY ROCHE-mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 N. BENTALOU ST., BALTIMORE, MD# 16

20e. Method of Disposition 10X Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK

20c. Location - City or Town, State 5-3-97 ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee Gladys Wanner

22. Name and Address of Facility WM. C. MARCH FH.-4300 WABASH AVE

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE NARCOTIC INTOXICATION ASSOCIATED WITH INTRACEREBRAL HEMORRHAGE

Immediate Cause (Final disease or condition resulting in death) ACUTE NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 40X Unknown

24a. Was an autopsy performed? 10X Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death? 10X Yes 20 No

25. Was case referred to medical examiner? 10X Yes 20 No

26. Place of Death (Check only one) Hospital: 10 Inpatient 20X Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death 10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending Investigation 60X Could not be determined

28a. Date of Injury (Month, Day Year) FOUND 4-28-97

28b. Time of Injury unknown M

28c. Injury at Work? 10 Yes 20X No

28d. Describe how injury occurred UNKNOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State) FOUND IN HOSPITAL BALTIMORE, MARYLAND

29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Dennis J. Chute MD

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) APRIL 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis Chute M.D. 141 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) APR 29 1997

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12962

## Certificate of Death

Reg. No.

|  |   |  |  |  |  |  |   |  |
|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><u>Willis Roach</u>   |  |  |  | 2. Date of Death<br>Month <u>April</u> Day <u>27</u> Year <u>1997</u>  |  | 3. Time of Death<br><u>0104 AM</u>                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Northwest Hospital Center</u>  |  |  |  | 4b. City, Town, or Location of Death<br><u>Randallstown</u>  |  | 4c. County of Death<br><u>Baltimore</u>                                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>217-20-8369</u>   |  | 6. Sex<br><u>1</u> M <u>2</u> F  |  | 7. Age (In yrs. last birthday)<br><u>69</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>March 22, 1928</u>            |  |
|  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>   |  | 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>Baltimore</u>  |  | 10c. City, Town or Location<br><u>Woodlawn</u>                          |  |
| To Be Completed by Funeral Director                                  | 10d. Inside City Limits<br><u>1</u> Yes <u>2</u> No   |  | 10e. Street and Number<br><u>6307 Windsor Mill Road</u>  |  | 10f. Zip Code<br><u>21207</u>  |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>                          |  |
|  | 11. Marital Status<br><u>1</u> Never Married <u>2</u> Married<br><u>3</u> Widowed <u>4</u> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><u>1</u> Yes <u>2</u> No<br>If Yes, Give Year or Dates: <u>46-47</u>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> Yes <u>2</u> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>11 Years</u><br>College (14 or 5+) <u>College</u>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Union Painter</u>  |  | 16b. Kind of Business/Industry<br><u>Local #1</u>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><u>Luther Roach</u>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Hattie Shifflett</u>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Mrs. Norma Anne Roach</u>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>6307 Windsor Mill Road Baltimore, MD 21207</u>   |  |   |  |
|  | 20a. Method of Disposition<br><u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State<br><u>4</u> Donation <u>5</u> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>MD Veterans Cemetery</u>  |  | 20c. Location - City or Town, State<br><u>4/30 Garrison, Maryland</u>  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><u>Stephen M. Jenkins</u>  |  |  |  | 22. Name and Address of Facility<br><u>Loring Byers Funeral Directors, Inc.</u><br><u>8728 Liberty Road Randallstown, MD 21133</u>                   |  |   |  |
|  | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><u>Acute Myocardial Infarction</u><br>Due to (or as a consequence of):<br><u>ASCD</u><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><u>1 HOUR</u><br><u>YEARS</u> |  |  |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown   |  |  |  |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><u>1</u> Yes <u>2</u> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><u>1</u> Yes <u>2</u> No   |  |  |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><u>1</u> Yes <u>2</u> No  |  | 26. Place of Death (Check only one)<br>Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br><u>1</u> Natural <u>5</u> Pending investigation<br><u>2</u> Accident <u>6</u> Could not be determined<br><u>3</u> Suicide <u>4</u> Homicide  |  | 28a. Date of injury (Month, Day Year)<br><u>April 27, 1997</u>   |  | 28b. Time of injury<br><u>M</u>  |  | 28c. Injury at work?<br><u>1</u> Yes <u>2</u> No                        |  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  | 29a. Certifier (Check only one)<br><u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  |  |  |   |  |
| State Registrar  | 29b. Signature and title of certifier<br><u>Robert Fine MD</u>  |  | 29c. License number<br><u>D 47587</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>April 28, 1997</u>   |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>ROBERT FINE MD Northwest Hospital Center Randallstown, MD</u>  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><u>APR 29 1997</u>              |   | 32. Registrar's Signature<br><u>Julie Davidson-Randall</u> |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed with 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed, it must be submitted to the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12963

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Andrea

Reid

2. Date of Death

Month  
APRILDay  
18Year  
1997

3. Time of Death

5:48p

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

UNKNOWN

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year  
SEPT. 13, 1947

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State  
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1502 KIA COURT

10f. Zip Code

21202

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12<sup>th</sup> GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

THOMAS

RISPER

18. Mother's Name (First, Middle, Maiden Surname)

BERNICE

PATTERSON

19a. Informant's Name/Relationship (Type, Print)

AUDREY SMITH (AUNT)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3710 CRANSTON AVE, BALTIMORE, MD. 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS CEMETERY 424-97 ARBUTUS, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.  
2140 N. FULTON AVE. BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Hemorrhage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HIV positive

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

APRIL 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DAVID J. BRADLEY, MD JOHN'S HOPKINS HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

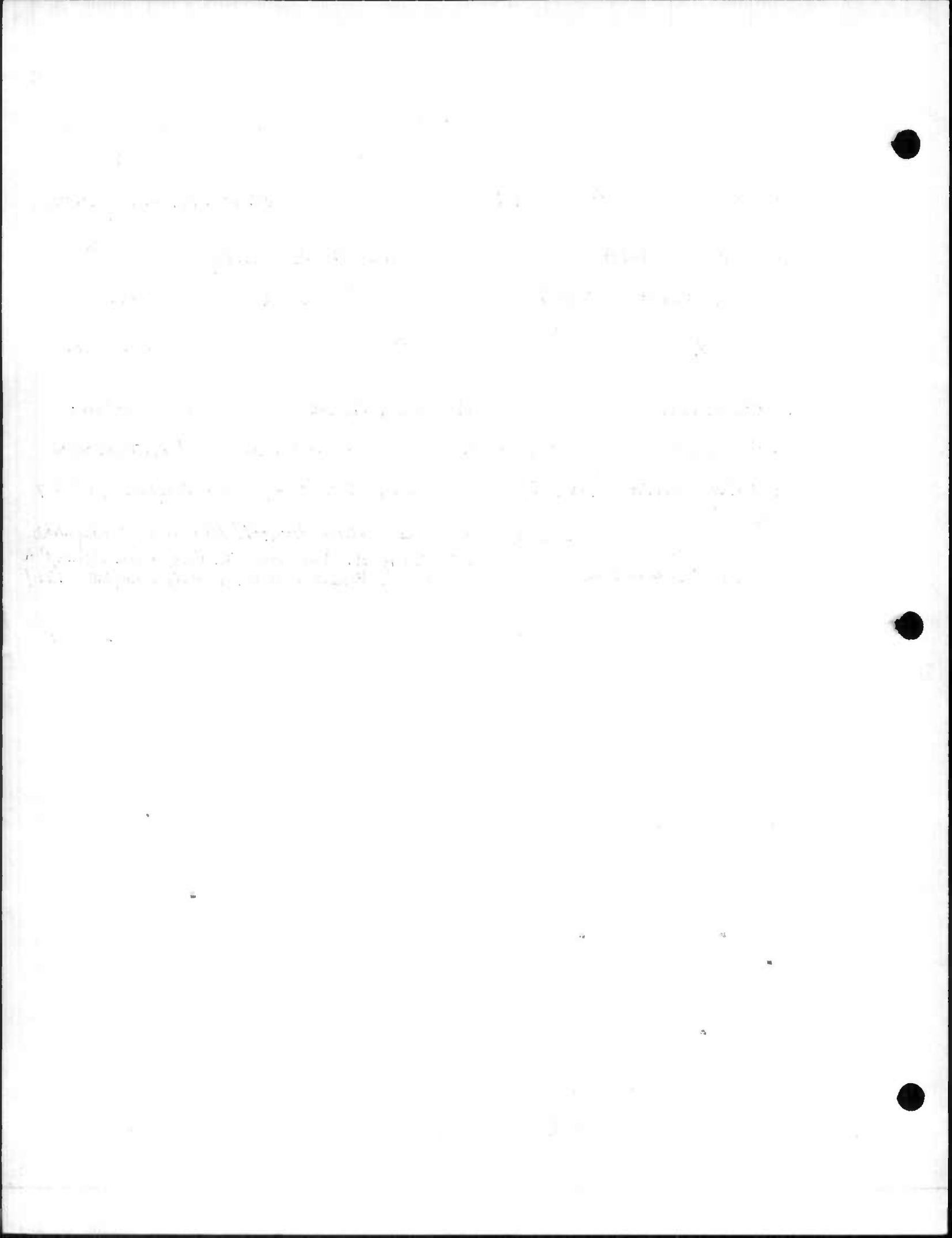
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12964

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>DANIEL HENRY ROGERS SR.</b>  |  |   |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>19</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>8:20 P.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3932 SUSANNA ROAD</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-16-9467</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>DEC 9, 1909</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>RANDALLSTOWN</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>3932 SUSANNA ROAD</b>  |  | 10f. Zip Code<br><b>21133</b>  |  | 10g. Citizen of What Country?<br><b>USA.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 yrs</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ELECTRICAL ENGINEER</b>           |  | 16b. Kind of Business/Industry<br><b>MARTIN MARIETTA</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>EDWARD ROGERS</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LEANNA TOOGOOD</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>PHYLLIS O'NEAL (DAUGHTER)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3932 SUSANNA RD. RANDALLSTOWN, MD. 21133</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>4-23-97 TIMONIUM, MARYLAND</b>  |  | 21. Signature of Funeral Service Licensee<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.</b>   |  | 22. Name and Address of Facility<br><b>2140 N. FULTON AVENUE, BALTIMORE, MD. 21217</b>  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immmediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>metastatic transitional renal cancer</b><br>Due to (or as a consequence of):<br><br>b. <b>transitional cell renal cancer</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><br><b>1997-1yr</b><br><br><b>3 yrs.</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day, Year)<br><b>4/21/97</b>  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>HOODSON, MD</b>   |  |
|   | 29c. License number<br><b>P10228</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>4/21/97</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>University of Maryland 22 South Greene St, Baltimore, MD 21201 Denise Hodyson, MD</b>   |  | 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  | 33. Date of Death (Month, Day, Year)<br><b>APR 19 1997</b>  |  | 34. Date of Death (Month, Day, Year)<br><b>APR 19 1997</b>   |  | 35. Date of Death (Month, Day, Year)<br><b>APR 19 1997</b>  |  |
|   | 36. Date of Death (Month, Day, Year)<br><b>APR 19 1997</b>  |  | 37. Date of Death (Month, Day, Year)<br><b>APR 19 1997</b>  |  | 38. Date of Death (Month, Day, Year)<br><b>APR 19 1997</b>   |  | 39. Date of Death (Month, Day, Year)<br><b>APR 19 1997</b>  |  |

2

Revised: 2004-01-01

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*Journal of Management Studies*, 19(1), 67-80.

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State of Maryland / Department of Health and Mental Hygiene

97 12965

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Albert

RIM

2. Date of Death

Month Day Year  
April 25, 1997

3. Time of Death

1:05 A.M.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

219-30-8107

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 12, 1914

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2043 Sue Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Automotive  
Repair

17. Father's Name (First, Middle, Last)

UNK.

18. Mother's Name (First, Middle, Maiden Surname)

Anna Emma Krause

19e. Informant's Name/Relationship (Type, Print)

Leonard R. Sligh/Caregiver

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2043 Sue Avenue Baltimore, MD 21221

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc. 4/25/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road Baltimore, MD 2122823e. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Bowel Infarction

Due to (or as a consequence of):

b. Ischemic Bowel Disease

Due to (or as a consequence of):

c. Mesenteric Artery Disease

Due to (or as a consequence of):

d. Arteriosclerotic Cardiovascular Disease

Approximate  
Interval Between  
Onset and Death

1 Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Marco Zamora MD

29c. License number

D40819

29d. Date signed (Month, Day, Year)

April 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marco Zamora M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12966

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kelly J. Rogers

2. Date of Death

Month  
AprilDay  
20Year  
1997

3. Time of Death

9:30 P.M.

4a. Facility Name (If not institution, give street and number)

Howard County Genral Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

224 03 4668

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 9, 1906

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5708 Gischel Street

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Carpentry

17. Father's Name (First, Middle, Last)

Thurman Rogers

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Owens

19a. Informant's Name/Relationship (Type, Print)

William Rogers / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8443 Rugby Road Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Mem. Park

Date

4/23/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Richard Gonce

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Congestive heart failure

Due to (or as a consequence of):

b.

Acute myocardial infarction

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

2 weeks

one day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic stenosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. R. Davidson

29c. License number

DD4387

29d. Date signed (Month, Day, Year)

April - 21 - 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. R. Davidson 4370 Pennington Ave Balto Md 21226

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 12967

### Certificate of Death

Reg. No.

**Division of Vital Records, P.O. Box 68760,**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12968

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Santos

2. Date of Death

Month

Day

Year

April

26

1997

3. Time of Death

6:25pm

4a. Facility Name (If not institution, give street and number)

Worren Frankford

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

218-01-8702

6. Sex

1 ☐ M2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Sept 1, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1713 N. PATTERSON PARK AVE.

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: PORTUGUESE

14. Race - American Indian, Black, White, etc.

Specify: NEGRO

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5TH

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LONGSHOREMAN

16b. Kind of Business/Industry

S.T.A.OF BALTO.INC.

17. Father's Name (First, Middle, Last)

FRANK SANTOS

18. Mother's Name (First, Middle, Maiden Surname)

JOSEPHINE JONES

19a. Informant's Name/Relationship (Type, Print)

SHARON WEEMS-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2608 CECIL AVE. BALTO, MD. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY MAY 2, 1997 BALTO, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Calvin B. Scruggs

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON STREET BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hr.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

osteomyelitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas J. Russi MD

29c. License number

D50785

29d. Date signed (Month, Day, Year)

April 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS J. RUSSI MD

10805 Hickory Ridge Rd Columbia MD

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital of Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12969

## Certificate of Death

Reg. No.

|   |   |                           |  |  |  |  |   |  |
|---|---|---------------------------|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John P. Scott</b>                                |                           |  |  | 2. Date of Death<br>Month: <b>April</b> Day: <b>25th</b> Year: <b>1997</b>   |  | 3. Time of Death<br><b>3:15 PM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOSEPH RITCHIE HOSPICE</b> |                           |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>n/a</b>                                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-16-4328</b>   |                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   | If Under 1 Year<br>Months: Days:   | If Under 24 Hrs.<br>Hours: Min.  | 8. Date of Birth<br>Month, Day, Year<br><b>JAN. 27, 1925</b>            |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>BALTIMORE, MD</b>                                |                           |  |  |  |  |   |  |
| Usual Residence of Decedent   |   |                           |  |  |  |  |   |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>n/a</b> |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>2327 KOKO LANE</b>   |   |                           |  | 10f. Zip Code<br><b>21216</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>marines</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): <b>-</b> College (1-4 or 5+): <b>6+ years</b>   |   |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TEACHER</b>                                      |  |  | 16b. Kind of Business/Industry<br><b>BALTIMORE CITY PUBLIC SCHOOLS</b> |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>KELLEY SCOTT</b>  |   |                           |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>TWEEDY MC DANIEL</b>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>GLADYS E. SCOTT-wife</b>   |   |                           |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2327 KOKO LANE, BALTIMORE, MD 21216</b>  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>crypt</b>  |   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEMORIAL</b>  |  | Date<br><b>4-30-97</b>   |  | 20c. Location - City or Town, State<br><b>ARBUTUS, MD</b>               |  |
| 21. Signature of Funeral Service Licensee<br><b>John March</b>  |   |                           |  | 22. Name and Address of Facility<br><b>WM. C. MARCH FH.-4300 WABASH AVE.</b>   |  |  |   |  |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |                           |  |  |  |  |   | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)<br><b>Cardiac Arrest</b>  |   |                           |  |  |  |  |   | <b>3 min</b>   |
| Due to (or as a consequence of):<br><b>Metastatic adenocarcinoma</b>  |   |                           |  |  |  |  |   | <b>1 yr</b>  |
| Due to (or as a consequence of):<br><b>Colon Ca</b>   |   |                           |  |  |  |  |   | <b>2 yrs</b>   |
| Due to (or as a consequence of):  |   |                           |  |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |                           |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                           |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                           |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |                           |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28d. Describe how injury occurred   |   |                           |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |                           |  | 29b. Signature and title of certifier<br><b>Daniel Finkelstein MD</b>  |  | 29c. License number<br><b>D04431</b>                                   |   | 29d. Date signed (Month, Day, Year)<br><b>4/25/97</b>  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Daniel Finkelstein, Wilmer, Johns Hopkins Balt MD</b>  |   |                           |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |   |                           |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

97 12970

Item 23a, 27, 28abcdef Per MEO Film G747 5-6-97 r Certificate of Death

Reg. No.

|   |  |                           |   |   |   |  |   |   |   |  |  |
|---|--|---------------------------|---|---|---|--|---|---|---|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>DONALD SCHMIDBAUER</b>                        |                           |   |   | 2. Date of Death<br>Month <b>APRIL</b> Day <b>23</b> Year <b>1997</b> |  |   |   | 3. Time of Death<br><b>4:15 PM</b>                                      |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>301 S. WOODYEAR ST.</b> |                           |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>              |  |   |   | 4c. County of Death<br><b>N/A</b>                                       |  |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>216-62-7641</b>  |                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 11, 1954</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |  |  |
|   | Usual Residence of Decedent  |                           |   |   |   |  |   |   |   |  |  |
| 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>N/A</b> |   | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                              |   |  |  |
| 10e. Street and Number<br><b>879 W. Lombard St.</b>   |  |                           |   | 10f. Zip Code<br><b>21223</b>   |   |  |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b></b>  |  |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |   |  |   | 16b. Kind of Business/Industry<br><b>Baltimore City</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Joseph Schmidbauer</b>  |  |                           |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Valerie Helen Dulskis</b>  |   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Valerie Schmidbauer - mother</b>   |  |                           |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>879 W. Lombard St., Baltimore, Md. 21223</b>   |   |   |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory, Inc.</b>   |   |  |   | 20c. Location - City or Town, State<br><b>4/28/97 Beltsville, Md.</b>   |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                           |   |   |   | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home at Meadowridge<br/>7250 Washington Blvd., Elkrige, Md. 21227</b>   |   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>ACUTE NARCOTIC INTOXICATION</b><br>Due to (or as a consequence of):<br><br>b. _____ Due to (or as a consequence of):<br><br>c. _____ Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                           |   |   |   |  |   |   |   | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                           |   |   |   |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   |  |                           |   |   |   |  |   |   |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   |  |                           |   |   |   |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |                           |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b> |   |  |   |   |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined   |  |                           |   | 28a. Date of Injury (Month, Day Year)<br><b>4-23-97</b>   |   | 28b. Time of Injury<br><b>unknown</b> M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |   | 28d. Describe how Injury occurred<br><b>unknown</b>  |  |
|   |  |                           |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND IN HOUSE</b>   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>301 S. WOODYEAR STREET BALTIMORE MD.</b> |   |  |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                           |   |   |   |  |   |   |   | 29b. Signature and title of certifier<br>   |  |
|   |  |                           |   |   |   |  |   |   |   | 29c. License number<br><b>O.C.M.E.</b>   |  |
|   |  |                           |   |   |   |  |   |   |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 24, 1997</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute mo 111 Penn Street, Baltimore, Maryland 21201</b>  |  |                           |   |   |   |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |  |                           |   | 32. Registrar's Signature<br>  |   |  |   |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12971

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

DHHM 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 12972

|  |  |  |   |   |  |                                |   |  |  |  |
|--|--|--|---|---|--|--------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>MANUEL JACOB SCHENKER  |  |   |   |  |                                | 2. Date of Death<br>Month Day Year<br>APR 25 1997   |  | 3. Time of Death<br>1025   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center  |  |   |   |  |                                | 4b. City, Town, or Location of Death<br>Annapolis   |  | 4c. County of Death<br>AA Co   |  |
| Funeral<br>Director  | 5. Social Security Number<br>214 05 1779   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>84  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>Jan 13, 1913   |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent  |  |   |   |  |                                |   |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>Md   |  | 10b. County<br>AA Co  |   | 10c. City, Town or Location<br>Annapolis   |                                |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br>2690 Carrollton Rd   |  |   |   | 10f. Zip Code<br>21401   |                                | 10g. Citizen of What Country?<br>USA  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 4   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>owner operator |  |                                | 16b. Kind of Business/Industry<br>footwear  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Louis Schenker  |  |   |   |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Fannie Lott  |  |  |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br>Rita C. Schenker   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2690 Carrollton Rd., Annapolis, Md. 21403   |                                |   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Kneseth Israel Cemetery   |   | Date<br>4/27/97  |                                | 20c. Location - City or Town, State<br>Annapolis, Md  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Charles Zanner</i>   |  |   |   | 22. Name and Address of Facility<br>ANNAPOLIS, MD. 21401<br>HARDESTY FUNERAL HOME PA 12 RIDGLEY AVE  |                                |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cardiac Arrest</i><br>Due to (or as a consequence of):<br>b. <i>Coronary Artery Disease</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate interval between Onset and Death<br><i>Immediate</i><br><i>many years</i> |  |   |   |  |                                |   |  |  |  |
|  | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>History of strokes</i>   |  |   |   |  |                                |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |                                | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |   |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |                                |   |  |  |  |
|  | 29b. Signature and title of certifier<br><i>R.L. Hochman, MD</i>   |  |   |   | 29c. License number<br>D05192  |                                | 29d. Date signed (Month, Day, Year)<br>4/25/97  |  |  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Richard I. Hochman, MD 1833A Forest Dr., Annapolis, Md. 21401  |  |   |   |  |                                |   |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>APR 29 1997   |  |   |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |                                |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

JA



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12973

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Winona Virginia Svitak

2. Date of Death

Month Day Year  
April 21 1997

3. Time of Death

5:40 A.M.

4a. Facility Name (If not institution, give street and number)

1918 Parksley Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

212 22 4585

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 25, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1918 Parksley Avenue

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9th

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Bar Maid

16b. Kind of Business/Industry

Bar

17. Father's Name (First, Middle, Last)

David Hoffman

18. Mother's Name (First, Middle, Maiden Surname)

Addie East

19a. Informant's Name/Relationship (Type, Print)

Karen Bowyer / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2613 Washington Blvd. Baltimore, Maryland 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

4/24/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Donna M. Zmierski

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Colon Ca metastatic to liver and lung 11 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease  
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Regina A. Svitak MD

29c. License number

D35626

29d. Date signed (Month, Day, Year)

April 21 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Regina A. Svitak MD  
3401 Benson Ave  
Balt MD 21227

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

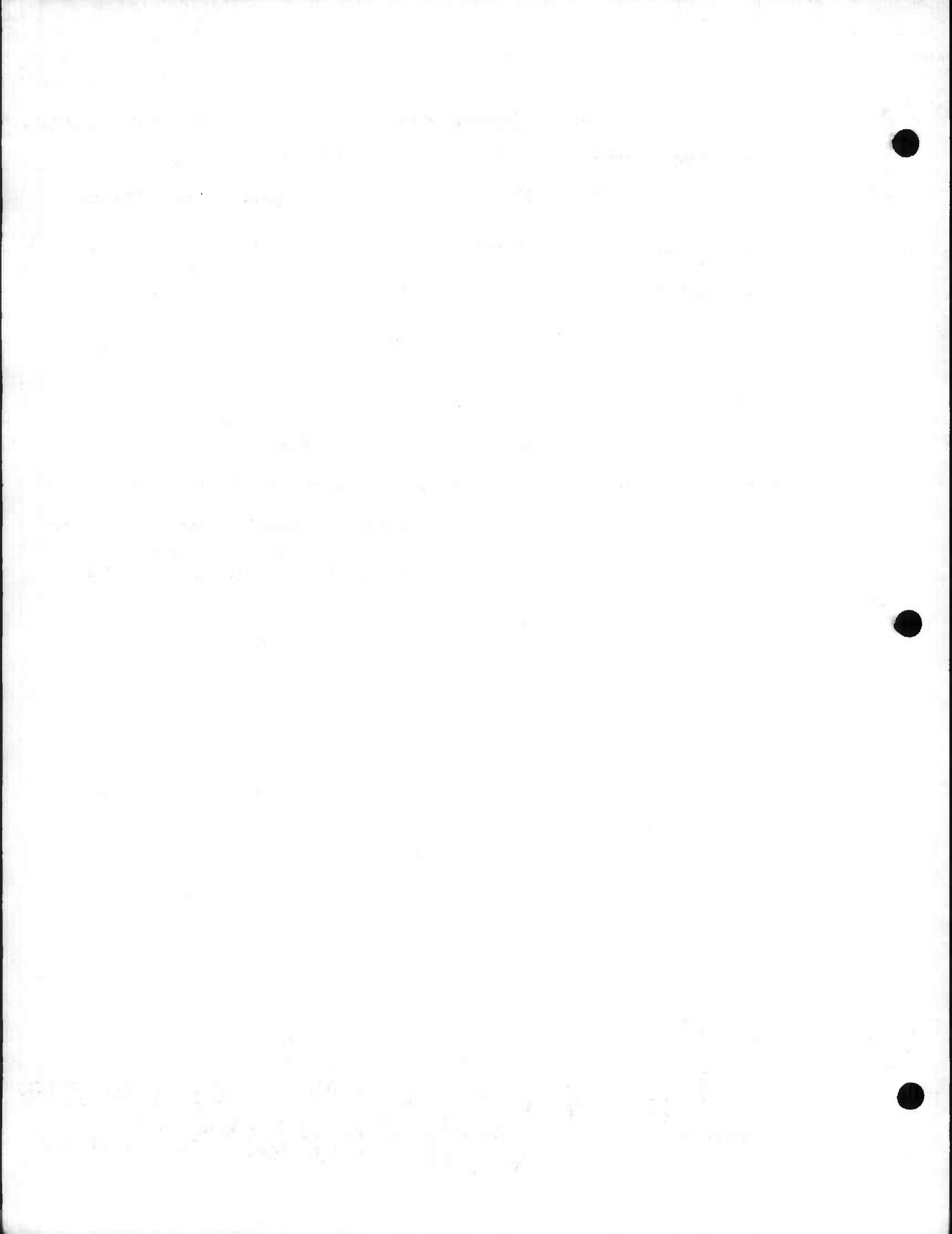
Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





## Replacement

**Physician  
/Medical  
Examiner**

## Funeral Director

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Physician  
/Medical  
Examiner

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

|   |  |   |   |  |  |  |  |   |  |
|---|--|---|---|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Nelson Webster Sorrell</b>   |  | 2. Date of Death<br>Month <b>March</b> Day <b>3</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>3:00 AM</b>   |  |  |  |   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Manorcare Nursing Center of Wheaton</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Wheaton</b>  |  | 4c. County of Death<br><b>Montgomery</b> |  |  |   |  |
| 5. Social Security Number<br><b>579-03-8782</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Mar 4, 1918</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Wash. DC</b> |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Wheaton</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>12513 Bushey Drive</b>   |  |   | 10f. Zip Code<br><b>20906</b>   |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>45-46</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>9</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bus Driver</b>              |  |  | 16b. Kind of Business/Industry<br><b>D.C. Transit</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Christopher Artemas Sorrell</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Sullivan</b>  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Fred Sorrell (son)</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12513 Bushey Dr., Wheaton, MD 20906</b> |  |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>   |   | Date<br><b>Mar 5 1997</b>  |  | 20c. Location - City or Town, State<br><b>Brentwood, MD</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Drive Gaithersburg, MD</b>                            |  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arrhythmia</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |   |  |  |  | Approximate Interval Between Onset and Death<br><b>Few Minutes</b>                             |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Malnutrition</b>   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                           |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br><b>D 42518</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 14, 1997</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Gul Chablani M.D. 11119 Rockville Pike, # 316, Rockville, MD 20852</b>   |  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 20 1997</b>   |  |   | 32. Registrar's Signature<br>                            |  |  |  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

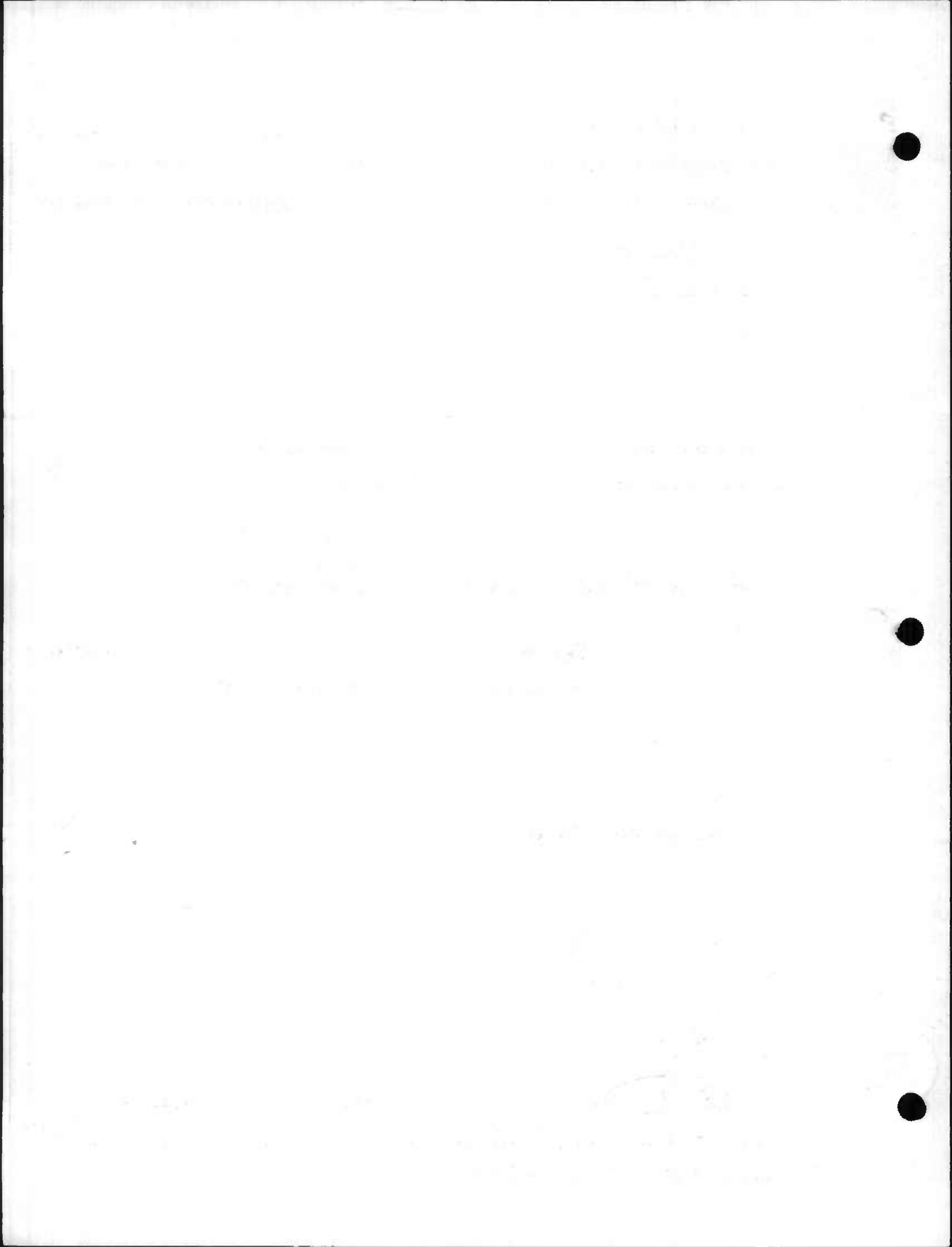
97 12975

|  |  |   |   |  |  |   |   |  |
|--|--|---|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>JAMES CHARLES SALMON   |   |   |  | 2. Date of Death<br>Month Day Year<br>April 26, 1997   |   | 3. Time of Death<br>22:00   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>WASHINGTON COUNTY HOSPITAL   |   |   |  | 4b. City, Town, or Location of Death<br>HAGERSTOWN   |   | 4c. County of Death<br>WASHINGTON   |  |
| Funeral<br>Director  | 5. Social Security Number<br>192-07-4902   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>88 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>AUG. 18, 1908  |  |
|  | 9. Birthplace (State or Foreign Country)<br>PENNSYLVANIA   |   | 10a. State<br>WV  |  | 10b. County<br>BERKELEY  |   | 10c. City, Town or Location<br>MARTINSBURG  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |
|  | 10e. Street and Number<br>416 SYCAMORE LANE  |   |   |  | 10f. Zip Code<br>25401   |   | 10g. Citizen of What Country?<br>U. S. A.   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>WHITE   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>MECHANIC                             |  | 16b. Kind of Business/Industry<br>AUTOMOBILE   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>CHARLES LEWIS SALMON  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>HAZEL CALER   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>JAMES F. SALMON/SON  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>416 SYCAMORE LANE, MARTINSBURG, WV 25401  |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>LAKEWOOD MEMORIAL GARDENS   |  | Date<br>4/24/97  |   | 20c. Location - City or Town, State<br>DORSEYVILLE, PA  |  |
|  | 21. Signature of Funeral Service Licensee<br>Charles M. Brown  |   |   |  | 22. Name and Address of Facility<br>BROWN FUNERAL HOME, 327 W. KING STREET<br>PO BOX 821, MARTINSBURG, WV 25401  |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Sepsis<br>Due to (or as a consequence of):<br>b. Acute Pancreatitis with pseudocyst<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  | Approximate Interval Between Onset and Death<br>24-48 hours  |   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Pericardial Stroke   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>K. P. Riddle, M.D.   |   | 29c. License number<br>D3876Y  |  | 29d. Date signed (Month, Day, Year)<br>4/21/97  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Kara P. Riddle, M.D. 1110 Medical Campus Rd Suite 100 Hagerstown MD 21742  |  | 31. Date filed (Month, Day, Year)<br>APR 29 1997  |   |  |  |   |   |  |
| 32. Registrar's Signature<br>John Davidson-Randall   |  |   |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

JA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12976

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Janice Marie Tucker

2. Date of Death

April 23 1997

3. Time of Death

5:00PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

10111 Davis Ave.

4b. City, Town, or Location of Death

Woodstock

4c. County of Death

Howard

5. Social Security Number

217-48-5001

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

08/07/1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Woodstock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1011 Davis Ave.

10f. Zip Code

21163

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Artist

16b. Kind of Business/Industry

Self-employed

17. Father's Name (First, Middle, Last)

Eugene Ricks Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Adams

19a. Informant's Name/Relationship (Type, Print)

Austin Tucker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10111 Davis Ave. Woodstock, MD 21163

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lorraine Park

Date

4-28

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Kathleen A. Weber CFSP

22. Name and Address of Facility

David J. Weber Funeral Home  
5311 Edmondson Ave. Balto. MD 21229

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

e.

metastatic lung cancer

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

6 mos.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury et  
work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Julia Davidson-Randall MD

29c. License number

D40850

29d. Date signed (Month, Day, Year)

April 25, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

YVONNE OTTAVIANO MD 900 CATHY AVE BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12977

Certificate of Death

Reg. No.

|  |  |   |   |  |  |  |  |   |
|--|--|---|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GUSSIE VOGEL</b>  |   |   |  | 2. Date of Death<br>Month <b>APR</b> Day <b>24</b> Year <b>97</b>  |  | 3. Time of Death<br><b>8 PM</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>680 Americana Dr., Apt. 51</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Eastport</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>132-22-7800</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                             | 8. Date of Birth (Month, Day, Year)<br><b>APR 24, 1997</b>   | 9. Birthplace (State or Foreign Country)<br><b>Poland</b> |
|  | Usual Residence of Decedent  |   |   |  |  |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Eastport</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
|  | 10e. Street and Number<br><b>680 Americana Dr., Apt. 51</b>  |   |   |  | 10f. Zip Code<br><b>2140</b>   |  |  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of His If Yes, specify Cuban<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                       |  | 14. Race<br><b>White</b>   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>   |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)<br><b>Business Owner</b>  |  | 18b. Occupation/Industry<br><b>Restaurant &amp; Lounge</b>   |  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Nathan Azoff</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Messer</b>   |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>PHYLLIS VOGEL</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 3218, ANNAPOLIS MD, 21403</b> |  |  |   |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | 20c. Date<br><b>4/25/97</b>  |  | 20d. Location - City or Town, State<br><b>Baltimore, MD</b>  |   |
|  | 21. Signature of Funeral Service Licensee<br><b>Edward A. Gregorchik</b>   |   |   |  | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>                   |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CHF</b><br>Due to (or as a consequence of):<br><b>HASCVD</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |   |   |  |  |  |  |   |
|  | 23b. Approximate Interval Between Onset and Death<br><b>36 h</b><br><b>year</b>  |   |   |  |  |  |  |   |
| Physician<br>/Medical<br>Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>gouty Ca, Osteoporosis,<br/>COPD Severe<br/>Hypothyroid</b>   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred                         |   |  |  |  |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |  |   |
| 29b. Signature and title of certifier<br><b>Michael J. Slapenta</b>  |  |   |   | 29c. License number<br><b>D2438</b>              |  | 29d. Date signed (Month, Day, Year)<br><b>25 April '97</b> |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL SLAPENTA 1060 RIDGEWAY AVE STE 120 ANNAPOLIS MD 21401</b>   |  |   |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b> |   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

97 12978

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |   |
|---|---|---|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Christine R Wilkins</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 25 1997</b>   |  | 3. Time of Death<br><b>5:15a</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death<br><b>N/A</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-20-4110</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 29, 1925</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>SOUTH CAROLINA</b>   |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>1314 N. KENWOOD AVENUE</b>   |   |   |  | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>NEGRO</b>                            |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b><br>College (1-4 or 5+) <b>N/A</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CROSSING GUARD</b>                    |  | 16b. Kind of Business/Industry<br><b>BALTIMORE CITY</b>  |  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>MICHAEL CLARK</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>RACHAEL</b>  |  |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>GEORGE A. WILKINS, SR.-HUSBAND</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1314 KENWOOD AVENUE BALTO, MD. 21213</b>   |  |  |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VETERAN CEM.</b>   |  | Date<br><b>APR. 29, 1997</b>   |  | 20c. Location - City or Town, State<br><b>OWINGS MILLS, MD.</b>                                    |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Calvin B. Scruggs, Jr.</b>  |   |   |  | 22. Name and Address of Facility<br><b>CALVIN B. SCRUGGS FUNERAL HOME<br/>1412 E. PRESTON ST. BALTO, MD. 21213</b>   |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Pulmonary Embolism</b><br>Due to (or as a consequence of):<br><b>b. Deep Venous Thrombosis</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>One Day</b><br><b>Two Days</b>   |
|   | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Thrombotic Thrombocytopenic Purpura</b><br><b>Atrial Fibrillation</b>   |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Karl P Kuhn MD</b>  |   | 29c. License number<br><b>RES 000</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>April twenty fifth, 1997</b>               |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Karl Kuhn Tower 110 Johns Hopkins Hospital</b>   |   |   |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |   | 32. Registrar's signature<br><b>J. Davidson-Randall</b>   |   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12979

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary T. Williams

2. Date of Death

Month  
AprilDay  
19Year  
1997

3. Time of Death

1:35 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Church Home Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

218-18-7472

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year

May 19, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

203 N. Spring Court

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dietician

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Frank Allen

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Floyd

19a. Informant's Name/Relationship (Type, Print)

Rebecca Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3608 Rosedale Road, Baltimore, Maryland 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

4-25-97

20c. Location - City or Town, State

REISTERSTOWN, MARYLAND

21. Signature of Funeral Service Licensee

J. H. Brown

22. Name and Address of Facility

Joseph H. Brown Jr. Funeral Home, PA.  
2140 N. Fulton Avenue, Baltimore, Maryland 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Invasive Transitional Bladder Cancer

April 2, 1997

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Left Partial Hydronephrosis

March 28, 1997

c. Urosepsis / Dehydration

April 17, 1997

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George E. Wicks M.D.

29c. License number

041365

29d. Date signed (Month, Day, Year)

April 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George E. Wicks M.D.

100 N. Broadway 21231

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

John A. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

2. In the second part of the paper, the author discusses the problem of the structure of the nucleus. It is shown that the structure of the nucleus is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

3. In the third part of the paper, the author discusses the problem of the structure of the molecule. It is shown that the structure of the molecule is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

4. In the fourth part of the paper, the author discusses the problem of the structure of the crystal. It is shown that the structure of the crystal is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

5. In the fifth part of the paper, the author discusses the problem of the structure of the liquid. It is shown that the structure of the liquid is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

6. In the sixth part of the paper, the author discusses the problem of the structure of the gas. It is shown that the structure of the gas is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

7. In the seventh part of the paper, the author discusses the problem of the structure of the plasma. It is shown that the structure of the plasma is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

8. In the eighth part of the paper, the author discusses the problem of the structure of the solid. It is shown that the structure of the solid is determined by the laws of quantum mechanics, which are based on the principle of the uncertainty of the position and momentum of the particles.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 12980

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Jeffries Williams

2. Date of Death

Month Day Year  
April 22, 1997

3. Time of Death

3:00PM

4a. Facility Name (If not Institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

NA

5. Social Security Number

217-22-8123

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

if Under 1 Year

Months Days

if Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
05-31-27

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

MD.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1300 E. Lanvale Street

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7th Grade

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

various trades

17. Father's Name (First, Middle, Last)

James H. Williams

18. Mother's Name (First, Middle, Maiden Surname)

Laura O'Neill

19a. Informant's Name/Relationship (Type, Print)

Felicia Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2522 Barnseley Plaza Plaza Baltimore, Md. 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Mem. Gardens 04-30-97 Dundalk, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Small cell lung carcinoma

six months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Non Small cell lung carcinoma

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. C. Dees M.D.

29c. License number

D 50325

29d. Date signed (Month, Day, Year)

April 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. C. Dees M.D. 600 North Wolfe Street Baltimore Maryland 21287

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Jana Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, II, 27 per ME0 G-747 5/29/97

Certificate of Death

Reg. No.

97 12981

|  |   |  |   |                                       |  |
|--|---|--|---|---------------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LESLIE WRIGHT</b>  |  | 2. Date of Death<br>Month <b>APRIL</b> Day <b>21</b> Year <b>1997</b>   |                                       | 3. Time of Death<br><b>10:46 P</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1806 n. fulton ave</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                       | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-42-9427</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.  | If Under 1 Year<br>Months Days        | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>December 1, 1941</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                       |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>md.</b>  |  | 10b. County<br><b>N/A</b>   |                                       | 10c. City, Town or Location<br><b>Baltimore</b>  |
|  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1806 N. Fulton Avenue</b>  |                                       | 10f. Zip Code<br><b>21217</b>  |
|  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |                                       | 15. Decedent's Education (Specify only highest grade completed)<br><b>5th grade</b>  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NEVER WORKED</b>  |  | 16b. Kind of Business/Industry<br><b>N/A</b>  |                                       | 17. Father's Name (First, Middle, Last)<br><b>Melvin Wright</b>  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Violet Adams</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Melvin Wright (father)</b>   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1806 N. Fulton Avenue, Baltimore, Maryland 21217</b>   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>  |                                       | 20c. Location - City or Town, State<br><b>4-24-97 Lansdowne, Maryland</b>  |
|  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>   |  | 22. Name and Address of Facility<br><b>Joseph H. Brown Jr. Funeral Home, P.A.<br/>2140 N. Fulton Avenue, Baltimore, Maryland 21217</b>  |                                       | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>                 |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                       | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |
| 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 28d. Describe how injury occurred     |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |                                       |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>[Signature]</b>  |   | 29c. License number<br><b>O.C.M.E</b> |  |
| 29d. Date signed (Month, Day, Year)<br><b>APRIL 22, 1997</b>   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARYSANTO D. KOSOW 111 Penn Street, Baltimore, Maryland 21201</b> |   |                                       |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>  |   |                                       |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12982

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harry Randolph Wrage

2. Date of Death

April 27 1997

3. Time of Death

6:05 pm

4a. Facility Name (If not institution, give street and number)

13 B-2 Spa Creek Landing

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

391-12-3075

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN 11, 1924

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

13 B-2 Spa Creek Landing

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 X Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 X Yes 2 No  
If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

General Electric

17. Father's Name (First, Middle, Last)

John R. Wrage

18. Mother's Name (First, Middle, Maiden Summa)

Mercedes E. Fischer

19a. Informant's Name/Relationship (Type, Print)

Stephen D. Wrage/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 B-2 Spa Creek Landing, Annapolis, MD 21403

20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 4/28/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriovenous aneurysm

Due to (or as a consequence of):

b. Coronary artery disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart and failure

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 X No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregory A. Mitchell, M.D.

29c. License number

D14758

29d. Date signed (Month, Day, Year)

4-28-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

621 Ridgely Ave #401 Annapolis, MD 21401

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

JA

10

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



97 12983

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen Wallis</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 26 1997</b>   |  | 3. TIME OF DEATH<br><b>7:20 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>144-05-7431</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APR 23, 1905</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New Jersey</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Vantage House</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Columbia</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Howard</b>  |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Howard</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Columbia</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>5400 Vantage Point Road</b>  |  |
| 10f. ZIP CODE<br><b>21044</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                    |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES        |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b> |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George Lafayette Mason</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence Spencer Pierson</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth E. Wallis</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15301-2A Beaverbrook Ct. Silver Spring, MD 20906</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 4/28/97 Baltimore, MD</b>  |  | 20c. LOCATION — City or Town, State   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Edward A. Gregorchik</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of MD., Inc. 299 Frederick Rd Baltimore, MD 21228</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular Accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Cerebrovascular Accident</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>WEEKS</b> |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  | 29c. LICENSE NUMBER<br><b>022855</b>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>APR 27, 1997</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Betty I Lewis, No 11055 Little Potomac Pk Columbia, Md 21046</b>   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>APR 29 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12984

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Theresa J. Wojcik

2. Date of Death

April 27

Day

1997

Year

3. Time of Death

10:00 P.M.

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare Hammonds Lane Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

216 07 1896

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 19, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

746 S. Decker Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

3rd

College (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Martins

17. Father's Name (First, Middle, Last)

Frank Jankowski

18. Mother's Name (First, Middle, Maiden Surname)

Ann (Not available)

19a. Informant's Name/Relationship (Type, Print)

Thomas Baranowski / nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21042  
2402 Woodstream Court Ellicott City, Maryland

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cemetery

Date

5/1/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Jerome Jankowski

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

DEMENTIA

Approximate Interval Between Onset and Death

ONE YEAR

e. Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ OOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Nature2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

S. Jankowski MD

29c. License number

D 21776

29d. Date signed (Month, Day, Year)

APRIL 28 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUNYA MURORA MD 203 E PATARSCO AVE BALTIMORE 21225

31. Date filed (Month, Day, Year)

APR 29 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director



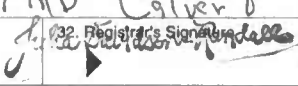
Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 12985**  
**Certificate of Death**

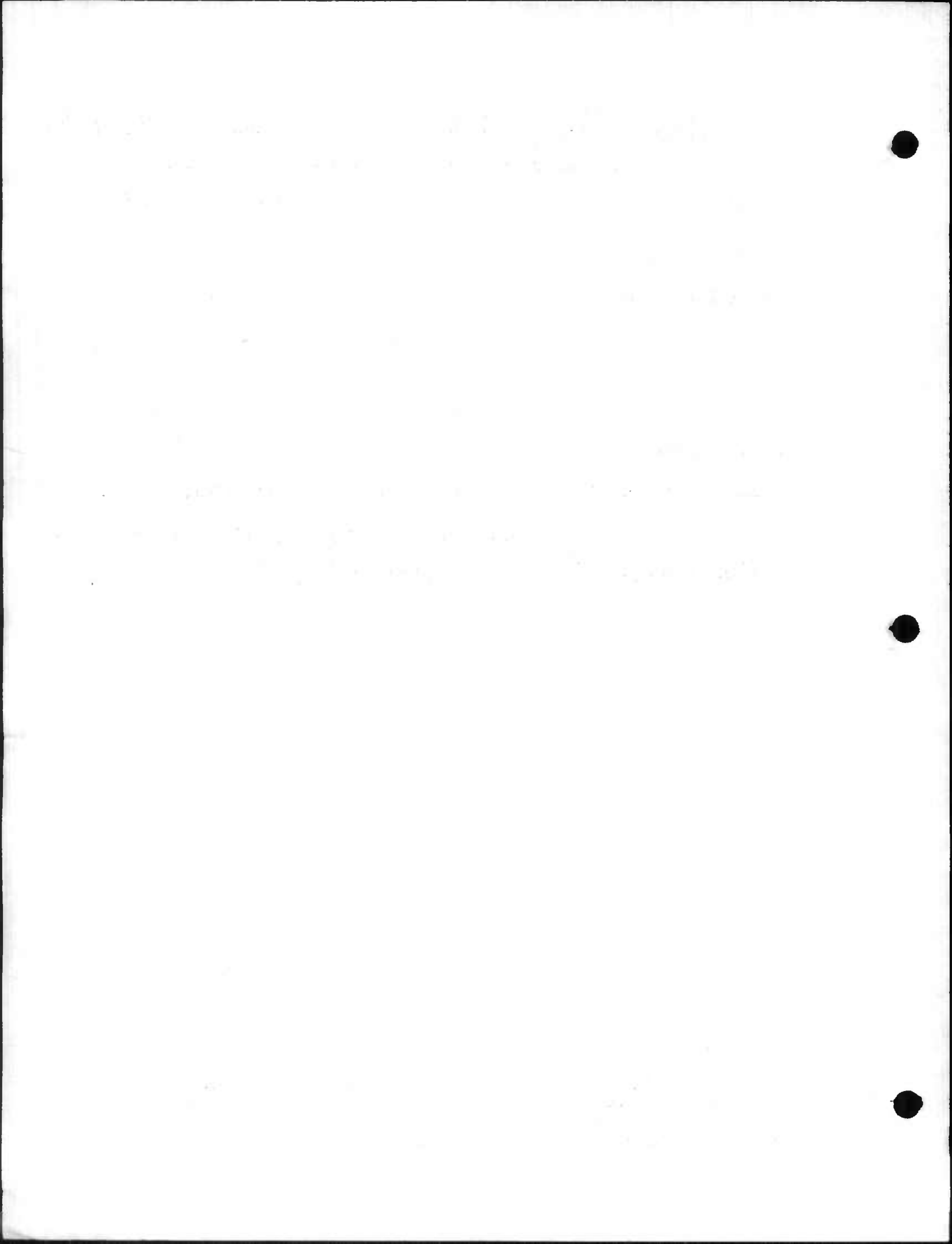
Reg. No.

|  |   |  |   |                                       |  |  |  |   |  |  |
|--|---|--|---|---------------------------------------|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Alice Jean Yust</b>  |  |   |                                       |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>25</b> Year <b>97</b>          |   | 3. Time of Death<br><b>4:45 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Manor Healthcare Center, Inc.</b>  |  |   |                                       |  |  | 4b. City, Town, or Location of Death<br><b>Rising Sun</b>                    |   | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>287-18-1034</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                                       | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 8, 1914</b>                   |   | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>  |  |
|  | Usual Residence of Decedent   |  |   |                                       |  |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>   |                                       | 10c. City, Town or Location<br><b>Bel Air</b>  |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>114 Lexington Road</b>   |  |   |                                       | 10f. Zip Code<br><b>21014</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                               |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12th grade</b>  |  |   |                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bookkeeper</b>   |  |  | 16b. Kind of Business/Industry<br><b>Refrigeration Co.</b>              |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>George Cleland</b>  |  |   |                                       |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gladys Cavanaugh</b> |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Stewart C. Yust (Son)</b>  |  |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>36 W. Cherry Street, Rising Sun, MD. 21911</b>   |  |  |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |                                       | Data<br><b>4/26/97</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>            |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |                                       | 22. Name and Address of Facility<br><b>Schimunek Funeral Home of Bel Air, Inc.<br/>610 W. MacPhail Road, Bel Air, MD. 21014</b>  |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Ventricular Arrhythmia</b><br>Due to (or as a consequence of):<br>b. <b>A-S-C-V-D</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |                                       |  |  |  |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |                                       |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b>  |   |  |   |                                       |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                       |  |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |                                       |  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                       |  |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |                                       |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred                                       |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br> |   | 29c. License number<br><b>D-11115</b> |  | 29d. Date signed (Month, Day, Year)<br><b>April 25-97</b>                        |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Neil R. Taylor MD, Calvert Healthcare, Rising Sun, MD 21911</b>   |   |  |   |                                       |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>  |   |  |   |                                       |  |  |  |   |  |  |
| 32. Registrar's Signature<br>   |   |  |   |                                       |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
 Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12986

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
|---|---|--|--|--|--|--|---|--|--|--|---|---------------------|--|---------------------|-----------------|-------------------------------|---------------|------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Zeiler</b>  |  |  |  | 2. Date of Death<br>Month <b>April</b> Day <b>25</b> Year <b>1997</b>  |  |   |  | 3. Time of Death<br><b>6:20 AM</b>   |  |   |                     |  |                     |                 |                               |               |                  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Mercy Medical Center</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |   |  | 4c. County of Death<br><b>N/A</b>  |  |   |                     |  |                     |                 |                               |               |                  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-12-0780</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 14, 1922</b>      |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |   |                     |  |                     |                 |                               |               |                  |
|   | Usual Residence of Decedent   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Glen Arm</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |                     |  |                     |                 |                               |               |                  |
|   | 10e. Street and Number<br><b>4221 Manorview Road</b>  |  |  |  | 10f. Zip Code<br><b>21057</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                    |  |  |  |   |                     |  |                     |                 |                               |               |                  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |   |                     |  |                     |                 |                               |               |                  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <b>5+</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Lawyer</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Internal Revenue Serv.</b>                                |  |   |                     |  |                     |                 |                               |               |                  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles George Zeiler</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine K. Siebenhaar</b>  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Catherine M. Zeiler/Sister</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4221 Manorview Road, Glen Arm, Maryland 21057</b>  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart of Jesus</b>   |  | Date<br><b>4/28/97</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b> |  |  |  |   |                     |  |                     |                 |                               |               |                  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Lilly &amp; Zeiler Inc. 700 S. Conkling Street 21224</b>  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Pneumonia</b></td> <td>Approximate Interval Between Onset and Death<br/><b>17 days</b></td> </tr> <tr> <td>b. <b>Emphysema</b></td> <td><b>15 years</b></td> </tr> <tr> <td>c. <b>Atrial Fibrillation</b></td> <td><b>2 days</b></td> </tr> <tr> <td>d. <b>Sepsis</b></td> <td><b>6 days</b></td> </tr> </table> |  |  |  |  |  |   |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Pneumonia</b> | Approximate Interval Between Onset and Death<br><b>17 days</b> | b. <b>Emphysema</b> | <b>15 years</b> | c. <b>Atrial Fibrillation</b> | <b>2 days</b> | d. <b>Sepsis</b> |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Pneumonia</b>   | Approximate Interval Between Onset and Death<br><b>17 days</b> |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
|   | b. <b>Emphysema</b>   | <b>15 years</b>  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
|   | c. <b>Atrial Fibrillation</b>   | <b>2 days</b>  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
|   | d. <b>Sepsis</b>  | <b>6 days</b>  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hemachromatosis</b>  |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 28e. Date of Injury (Month, Day, Year)  |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 28f. Time of Injury<br><b>M</b>   |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 28g. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 29b. Signature and title of certifier<br><b>Vijay Pethkar</b>   |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 29c. License number<br><b>D 0050853</b>   |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 29d. Date signed (Month, Day, Year)<br><b>April 25, 1997</b>  |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vijay Pethkar, M.D. 301 St. Paul street, Baltimore MD 21202.</b>   |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1997</b>   |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |
| 32. Registrar's Signature<br><b>John A. Wilson-Randall</b>  |   |  |  |  |  |  |   |  |  |  |   |                     |  |                     |                 |                               |               |                  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital: Attending Physician: The law requires that the death certificate be executed within 4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12987

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |                          |   |  |  |                                   |   |  |  |
|---|---|--|---|---|--|--------------------------|---|--|--|-----------------------------------|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>E. L. Andrews</i>  |  |   |   | 2. Date of Death<br>Month <i>April</i> Day <i>21</i> Year <i>1997</i>  |                          |   |  | 3. Time of Death<br><i>3:45 AM</i>   |                                   |   |  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Keswick Nursing Home</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                          |   |  | 4c. County of Death<br><b>N/A</b>  |                                   |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-03-6576</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   |                          | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |                                   | 8. Date of Birth (Month, Day, Year)<br><b>May 12, 1910 Maryland</b> |  |  |
|   | Usual Residence of Decedent   |  |   |   |  |                          |   |  |  |                                   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md</b>   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |                          |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                   |   |  |  |
|   | 10e. Street and Number<br><b>3339 Beech Avenue</b>  |  |   |   | 10f. Zip Code<br><b>21211</b>  |                          |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |                                   |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                          |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |                                   |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>Operator</b>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Operator</b>   |                          |   |  | 16b. Kind of Business/Industry<br><b>Phone Co.</b>   |                                   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Edward Pierce</b>   |  |   |   |  |                          | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cora Pearce</b> |  |  |                                   |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Albert W. Andrews</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3339 Beech Avenue Balto, Md 21211</b>  |                          |   |  |  |                                   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lorraine Park Cemetery 4/24 Woodlawn, MD</b>  |                          |   |  | 20c. Location - City or Town, State  |                                   |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Michael Carpenter</i>   |  |   |   | 22. Name and Address of Facility<br><b>Burgee-Henss Funeral Home<br/>Baltimore, Maryland 21211</b>   |                          |   |  |  |                                   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Diverticulitis, acute</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>b. Due to (or as a consequence of):</i><br><i>c. Due to (or as a consequence of):</i><br><i>d. Due to (or as a consequence of):</i> |  |   |   |  |                          |   |  |  |                                   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Advanced dementia</i>  |  |   |   |  |                          |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |   |  |                          |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                          |   |  |  |                                   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   |  |   | 28e. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred |   |  |  |
|   |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                          |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |  |                          |   |  |  |                                   |   |  |  |
| 29b. Signature and title of certifier<br><i>Dr. Isabelle MacGregor MD</i>   |   |  |   | 29c. License number<br><b>D13657</b>  |  |                          |   | 29d. Date signed (Month, Day, Year)<br><b>April 30, 1997</b>   |  |                                   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. Isabelle MacGregor, Keswick, 700 W 40th Street, Md 21211</b>  |   |  |   |   |  |                          |   |  |  |                                   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 1997</b><br><i>John Davidson-Randall</i>   |   |  |   |   |  |                          |   |  |  |                                   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: The law requires that the death certificate has been signed by the attending physician and completely filed in the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12988

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ISAAH BLAKE SR.

2. Date of Death

April 26, 1997

3. Time of Death

3:02P

4a. Facility Name (If not institution, give street and number)

1012 North Woodington Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

248-38-8613

6. Sex

15 M 20 F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 28, 1928

9. Birthplace (State or Foreign Country)

SC.

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1012 North Woodington Road

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Oven Operator

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Mike Blake

18. Mother's Name (First, Middle, Maiden Surname)

Nora Jackson

19a. Informant's Name/Relationship (Type, Print)

Loretta Blake (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5151 Stamford Road Baltimore, Md 21229

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem Park

Date

4/30/97

20c. Location - City or Town, State

Arbutus, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Caple Funeral Service

5502 Winner Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Bronchogenic Carcinoma, bilateral*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Metastatic Carcinoma, vertebral*  
Due to (or as a consequence of):c. *Emphysema*  
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph H Miller MD

29c. License number

A06982

29d. Date signed (Month, Day, Year)

4/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH H. MILLER MD

900 Cation Ave Baltimore Md 21229

31. Date filed (Month, Day, Year)

APR 30 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 4 abc per PHY Film G746 4-30-97 rja

State of Maryland / Department of Health and Mental Hygiene

97 12989

## Certificate of Death

Reg. No.

|  |  |  |  |  |   |   |  |                                   |   |  |  |
|--|--|--|--|--|---|---|--|-----------------------------------|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ERNESTINE BEARD</b>                         |  |  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>04/20/97</b>  |                                   | 3. Time of Death<br><b>8:00 pm.</b>                   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1320 LINWOOD AVE.</b> |  |  |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                       |                                   | 4c. County of Death<br><b>N/A</b>                     |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-28-6018</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>64</b>     |   | 8. Date of Birth (Month, Day, Year)<br><b>JAN 25, 1933</b>                                     |                                   | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |  |  |
|  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b> |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                   |   |  |  |
| 10e. Street and Number<br><b>1320 LINWOOD AVE</b>  |  | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |  |                                   |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |  |                                   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12yrs</b><br>College (1-4 or 5+) <b>2nd</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NURSE</b>  |  | 16b. Kind of Business/Industry<br><b>HOSPITAL</b>  |   |   |  |                                   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>CLARENCE BUTLER</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>THELMA DIXON</b>   |  |  |   |   |  |                                   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARVIN BEARD</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1320 N. LINWOOD AVE BALTO, MD 21213</b>  |  |  |   |   |  |                                   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEM PK</b>  |  | Date<br><b>APR 24 1997</b>   |   | 20c. Location - City or Town, State<br><b>ARBUTUS, MD</b>                                   |  |                                   |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Patricia [Signature]</i>   |  | 22. Name and Address of Facility<br><b>BETTS FUNERAL HOME</b><br><b>1129 N. CAROLINE ST BALTO, MD 21213</b>  |  |  |   |   |  |                                   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Coronary Heart Disease</b><br>Due to (or as a consequence of):<br><b>b. Hypertensive Heart Disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>Sudden</b>  |  |  |   |   |  |                                   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiac arrhythmia</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |   |  |                                   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |                                   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |                                   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><i>[Signature] MD</i>   |  | 29c. License number<br><b>D15533</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4/21/97</b>                                       |  |                                   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CHRYSOLOGUE GAKUBA</b><br><b>2 RESERVOIR CIRCLE, Pikesville</b><br><b>Suite 105 Md 21208</b>  |  |  |  |  |   |   |  |                                   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 1997</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |   |  |                                   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

12990

Item 26 per PHY Film G746 4-30-97 rja 6/9/97 reb

Items: 1 per Physician, Item: 13 per Informant

## Certificate of Death

Reg. No.

|                                     |   |  |   |                                |   |  |
|-------------------------------------|---|--|---|--------------------------------|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Ray J. Beasley, Jr. M.D.  |  | 2. Date of Death<br>Month Day Year<br>April 21, 1997  |                                | 3. Time of Death<br>1:00 AM   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br>1312 Margarette Ave.  |  | 4b. City, Town, or Location of Death<br>Towson  |                                | 4c. County of Death<br>Baltimore  |  |
| Funeral<br>Director                 | 5. Social Security Number<br>217-14-6307  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>73 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>Dec. 28, 1923   |
|                                     | 9. Birthplace (State or Foreign Country)<br>Pa.   |  |   |                                |   |  |
| To Be Completed by Funeral Director | Usual Residence of Decedent   |  |   |                                |   |  |
|                                     | 10a. State<br>Md.   | 10b. County<br>Baltimore   | 10c. City, Town or Location<br>Towson   |                                |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|                                     | 10e. Street end Number<br>1312 Margarette Ave.  |  | 10f. Zip Code<br>21286  |                                | 10g. Citizen of What Country?<br>USA  |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW-II   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |   |                                |   |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Radiologist  |                                | 16b. Kind of Business/Industry<br>Md. General Hospital  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br>Ray J. Beasley, Sr.  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Violet Hall  |                                |   |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Nancy Beasley/wife   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1312 Margarette Ave. Towson, Md. 21286   |                                |   |  |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.   |                                | 20c. Location - City or Town, State<br>4/22/97 Towson, Md.  |  |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204   |                                |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Lung Cancer<br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):                                  |  |   |                                |   | Approximate Interval Between Onset and Death   |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE |                                |   |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|                                     | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |   |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |                                |   |  |
|                                     | 29b. Signature and title of certifier<br>Henri Nammour M.D.   |  | 29c. License number<br>D35890   |                                | 29d. Date signed (Month, Day, Year)<br>04, 22, 97   |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>HENRI NAMMOUR 827 LINDEN AVE BALTO MD 21201   |  |   |                                |   |  |
|                                     | 31. Date filed (Month, Day, Year)<br>APR 30 1997  |  | 32. Registrar's Signature<br>Julia Davidson-Rendell   |                                |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12991

|   |  |   |   |  |  |  |                                |  |
|---|--|---|---|--|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Alfred Paul Buchta                           |   |   |  | 2. Date of Death<br>Month Day Year<br>April 29, 1997 |  | 3. Time of Death<br>10:45 P.M. |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Manor Care Roland Park |   |   |  | 4b. City, Town, or Location of Death<br>Baltimore    |  | 4c. County of Death<br>N/A     |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-03-0487   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>79 Yrs. | 8. Date of Birth (Month, Day, Year)<br>April 6, 1918   | 9. Birthplace (State or Foreign Country)<br>Maryland |  |                                |  |
|   | Usual Residence of Decedent  |   |   |  |  |  |                                |  |
| 10a. State<br>Maryland  |  | 10b. County<br>N/A  |   | 10c. City, Town or Location<br>Baltimore   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                |  |
| 10e. Street and Number<br>3917 Yolando Road   |  |   |   | 10f. Zip Code<br>21218   |  | 10g. Citizen of What Country?<br>U.S.A.  |                                |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+) 3 years   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Supervisor / Clerical   |  | 16b. Kind of Business/Industry<br>Government   |                                |  |
| 17. Father's Name (First, Middle, Last)<br>Otto Buchta  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sophie unknown  |  |  |                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Rosaleen Buchta (wife)  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3917 Yolando Road Baltimore, Maryland 21218   |  |  |                                |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Moreland Memorial Park  |   | 20c. Location - City or Town, State<br>5-2-97 Baltimore, Maryland  |  |  |                                |  |
| 21. Signature of Funeral Service Licensee<br><i>George Ferrante</i>   |  |   |   | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Home<br>6500 York Road Baltimore, Maryland 21212  |  |  |                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>UROSEPSIS</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |  |  |                                |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  |  |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |  |                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>KORSAKOFF DEMENTIA</u>   |  |   |   |  |  |  |                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  |  |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |   |  |  |  |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |                                |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28d. Describe how injury occurred  |  |  |                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |  |  |                                |  |
| 29b. Signature and title of certifier<br><i>Joseph W. Ferrante</i>  |  |   |   | 29c. License number<br>D-22334   |  | 29d. Date signed (Month, Day, Year)<br>30 April 1997   |                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Joseph W. Ferrante</i> 3825 Greenspring Avenue Baltimore 21211   |  |   |   |  |  |  |                                |  |
| 31. Date filed (Month, Day, Year)<br>APR 30 1997  |  |   |   | 32. Registrar's Signature<br><i>R. Tisdell</i>   |  |  |                                |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12992

## Certificate of Death

Reg. No.

|   |  |                          |   |  |   |  |  |  |  |  |  |
|---|--|--------------------------|---|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Ruth Frederick Boggs                       |                          |   |  | 2. Date of Death<br>Month Day Year<br>April 28 1997   |  |  | 3. Time of Death<br>12:10 a.m.   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Stella Maris Hospice |                          |   |  | 4b. City, Town, or Location of Death<br>Towson  |  |  | 4c. County of Death<br>Baltimore   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>212-05-3171   |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>88 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>February 2, 1909                              |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |  |
|   | Usual Residence of Decedent  |                          |   |  |   |  |  |  |  |  |  |
| 10a. State<br>Maryland  |  | 10b. County<br>Baltimore |   | 10c. City, Town or Location<br>Towson  |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br>6920 Donachie Rd.   |  |                          |   | 10f. Zip Code<br>21239   |   |  | 10g. Citizen of What Country?<br>United States                                       |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs.   |  |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker |   |  | 16b. Kind of Business/Industry<br>Own Home   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>John Wesley Frederick  |  |                          |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Pearl Roberts  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>John Boggs/son  |  |                          |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4 Foreston Valley Ct. Parkton, MD 21120  |  |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Greenmount Crematory  |  | Date<br>4/29/97   |  | 20c. Location - City or Town, State<br>Baltimore, Maryland                           |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                          |   |  | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Home, Inc.<br>6500 York Rd.<br>Baltimore, MD 21212   |  |  |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Large Cell Lymphoma<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                          |   |  |   |  |  |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                          |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
|   |  |                          |   |  |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|   |  |                          |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                          | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |                          | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred                    |  |  |
|   |  |                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                          |   |  |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |                          |   |  | 29c. License number<br>D 15504  |  | 29d. Date signed (Month, Day, Year)<br>April 28, 1997                                |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Eddie Nakhuda, M.D. 2300 Dulaney Valley Road, Towson, MD 21204  |  |                          |   |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 30 1997  |  |                          | 32. Registrar's Signature<br>  |  |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12993

## Certificate of Death

Reg. No.

|  |  |   |                   |  |   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|--|--|---|-------------------|--|---|--|---|--|---|------------------------------|--|-------|--|--|------|--|-------------------------------------|--|--|-------------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ASBERRY BUTLER SR.   |   |                   |  | 2. Date of Death<br>Month: April Day: 20 Year: 1997   |  | 3. Time of Death<br>3:00 pm   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Union Memorial Hospital  |   |                   |  | 4b. City, Town, or Location of Death<br>Baltimore   |  | 4c. County of Death<br>N/A  |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| Funeral<br>Director  | 5. Social Security Number<br>245-16-5231   |   | 6. Sex<br>1 M 2 F |  | 7. Age (in yrs. last birthday)<br>80 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Oct 1, 1916  |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | 9. Birthplace (State or Foreign Country)<br>SC   |   | 10a. State<br>MD  |  | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>Baltimore  |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 Yes 2 No  |   |                   |  | 10e. Street and Number<br>3000 GRAYSON ST   |  | 10f. Zip Code<br>21216  |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | 10g. Citizen of What Country?<br>US  |   |                   |  | 11. Marital Status<br>1 Never Married 2 Married 3 Widowed 4 Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 Yes 2 No   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| To Be Completed by Physician/Medical Examiner  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 Yes 2 No Specify:  |   |                   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Machinist   |   |                   |  | 16b. Kind of Business/Industry<br>Bottling Industry   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br>Luther Butler   |   |                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>KLANNA White   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>GRACIE GRANT   |   |                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3104 Cambridge Rd, Balt. Md 21207  |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| To Be Completed by Physician/Medical Examiner  | 20a. Method of Disposition<br>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)   |   |                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>King Memorial Park  |  | 20c. Location - City or Town, State<br>Randallstown, Md   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | 21. Signature of Funeral Service Licensee<br>Dunmore L. Redd   |   |                   |  | 22. Name and Address of Facility<br>Redd Funeral Service 1221 N. Monroec St 21217   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| To Be Completed by Physician/Medical Examiner  | Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |                   |  |   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. metastatic adenocarcinoma</td> <td>Approximate Interval Between Onset and Death</td> <td>month</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of):<br/>Coronary Artery Disease</td> <td>Year</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> <td></td> </tr> </table> |   |                   |  |   |  |   |  | Immediate Cause (Final disease or condition resulting in death) | a. metastatic adenocarcinoma | Approximate Interval Between Onset and Death | month | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of):<br>Coronary Artery Disease | Year |  | c. Due to (or as a consequence of): |  |  | d. Due to (or as a consequence of): |  |
| Immediate Cause (Final disease or condition resulting in death)  | a. metastatic adenocarcinoma   | Approximate Interval Between Onset and Death  | month             |  |   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of):<br>Coronary Artery Disease   | Year  |                   |  |   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | c. Due to (or as a consequence of):  |   |                   |  |   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | d. Due to (or as a consequence of):  |   |                   |  |   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | To Be Completed by Physician/Medical Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>myocardial infarction - old |                   |  |   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 Yes 2 No 3 Probably 4 Unknown  |  |   |                   |  |   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| To Be Completed by Physician/Medical Examiner  | 24a. Was an autopsy performed?<br>1 Yes 2 No   |   |                   |  |   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 Yes 2 No  |   |                   |  |   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 Yes 2 No   |   |                   |  | 26. Place of Death (Check only one)<br>Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | 27. Manner of Death<br>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined   |   |                   |  | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>28c. Injury at Work? 1 Yes 2 No  |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| To Be Completed by Physician/Medical Examiner  | 28d. Describe how injury occurred  |   |                   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |                   |  | 29a. Certifier (Check only one)<br>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| To Be Completed by Physician/Medical Examiner  | 29b. Signature and title of certifier<br>Dr. L. Redd   |   |                   |  | 29c. License number<br>D22031   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | 29d. Date signed (Month, Day, Year)<br>4-23-97   |   |                   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Lenny S. Perry 2116 Maryland Ave Balt. Md.  |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
| To Be Completed by Physician/Medical Examiner  | 31. Date filed (Month, Day, Year)<br>APR 30 1997   |   |                   |  | 32. Registrar's Signature<br>Julia Davidson-Randall   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |
|  | 33. Registrar's Signature  |   |                   |  |   |  |   |  |   |                              |  |       |  |  |      |  |                                     |  |  |                                     |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12994

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Lorenzo Brafa

2. Date of Death

April 29 1997

3. Time of Death

6:08 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

11 Dakin Court

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

5. Social Security Number

218-18-5229

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 15, 1910

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11 Dakin Court

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Salvatore Brafa

18. Mother's Name (First, Middle, Maiden Surname)

Nunziata DiPietro

19a. Informant's Name/Relationship (Type, Print)

Virginia E. Brafa /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 Dakin Court Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Most Holy Redeemer Cem.

Date

5/2/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Mark T. Zavoyna

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. CHF - Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Cor Pulmonale

Due to (or as a consequence of):

c. Emphysema

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9101 Franklin Sq Dr. Suite 205 Balto, Md 21237

31. Date filed (Month, Day, Year)

APR 30 1997

32. Registrar's Signature

J. A. Davidson-Randall

State  
Registrar

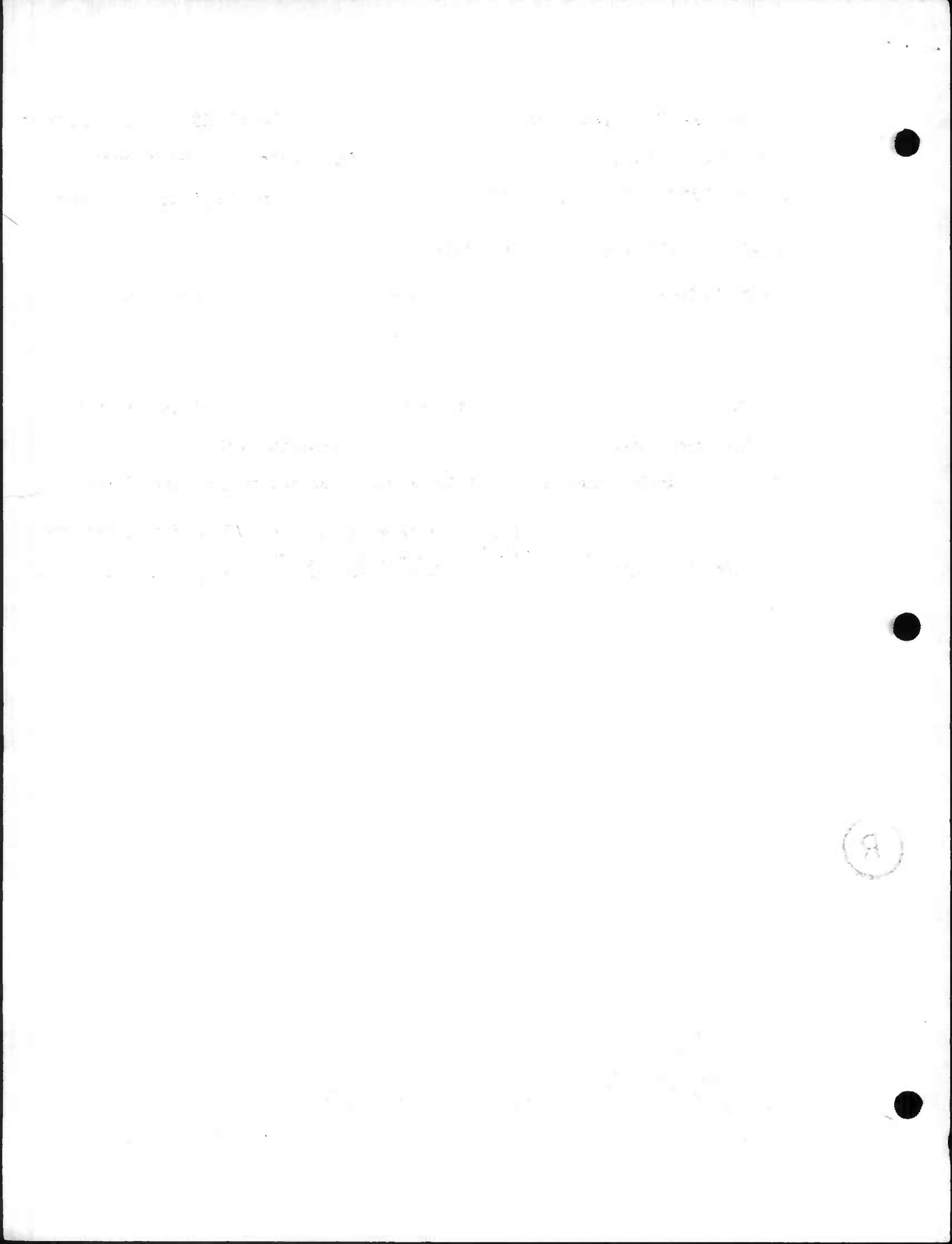
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The information on this death certificate is to be completed by the attending physician and the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 2 should be attached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12995

## Certificate of Death

Reg. No.

|   |   |                                      |   |  |  |                                |  |   |
|---|---|--------------------------------------|---|--|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT C BERGER</b>  |                                      |   |  | 2. Date of Death<br>Month <b>04</b> Day <b>27</b> Year <b>97</b>   |                                | 3. Time of Death<br><b>1650</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>UNIV of MARYLAND - SHOCK TRAUMA CTR</b>  |                                      |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                | 4c. County of Death<br><b>BALTIMORE</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-26-9293</b>   |                                      | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.       | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>May 3, 1939</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent   |                                      |   |  |  |                                |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |                                      | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>2120 Whistler Avenue</b>   |                                      |   |  | 10f. Zip Code<br><b>21230</b>  |                                | 10g. Citizen of What Country?<br><b>United States</b>  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance Mechanic</b>  |  | 16b. Kind of Business/Industry<br><b>State of Maryland</b>   |                                |  |   |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>William Berger</b>  |                                      |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lydia Fritz</b>  |                                |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Judith Berger, wife</b>  |                                      |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2120 Whistler Avenue Baltimore, Maryland 21230</b>                                       |                                |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |  | Date<br><b>5/1/97</b>  |                                | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                              |   |
|   | 21. Signature of Funeral Service Licensee<br>   |                                      | 22. Name and Address of Facility<br><b>Ambrose Funeral Home, Inc.<br/>1328 Sulphur Spring Road</b>  |  | Arbutus<br><b>21227</b>  |                                |  |   |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. UNKNOWN - PRESUMED SEPSIS</b><br>Due to (or as a consequence of):<br><b>b. HYPOTENSION</b><br>Due to (or as a consequence of):<br><b>c. RENAL FAILURE, ACUTE</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                      |   |  |  |                                |  | Approximate Interval Between Onset and Death                |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEPTIC SHOCK</b><br><b>METASTATIC RENAL CELL CARCINOMA</b><br><b>CORONARY ARTERY DISEASE</b>   |                                      |   |  |  |                                |  |   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |                                      |   |  |  |                                |  |   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                      |   |  |  |                                |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                      |   |  |  |                                |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                      | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |                                      | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|   | 28d. Describe how injury occurred   |                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |                                      |   |  |  |                                |  |   |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>P10336</b> |   | 29d. Date signed (Month, Day, Year)<br><b>04/27/97</b> |  |                                |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>P. G. GIBERSON, UMMS, 22 S. GREENE ST, BALTIMORE, MD</b> |   |                                      |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 1997</b>   |   | 32. Registrar's Signature<br>        |   |  |  |                                |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: This requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate is signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 12996

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Beck

2. Date of Death

April

Day

22

3. Time of Death

Year

1997

9:03 pm

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-28-6928

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 19, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Linthicum

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1119 Old Elkridge Landing Road

10f. Zip Code

21090

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

4/52

2/55

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

carpenter

16b. Kind of Business/Industry

Home Remodeling

17. Father's Name (First, Middle, Last)

Albert E. Beck

18. Mother's Name (First, Middle, Maiden Surname)

Edith Oliva Potts

19a. Informant's Name/Relationship (Type, Print)

Eleanor Beck, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1119 Elkridge Landing Road Linthicum, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans

Date

4/25

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ambrose Funeral Home, Inc.

1328 Sulphur Spring Road

Arbutus

21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] Resident Physician

29c. License number

AS 2441614-41

29d. Date signed (Month, Day, Year)

April 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED N ZAFAR, HARBOR HOSPITAL CENTER

31. Date filed (Month, Day, Year)

APR 30 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This requires that the death certificate be executed within 24 hours after death.


To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner


To Be Completed by Funeral Director



VOID

CERTIFICATE  BABY FETAL  
97-12997 - COLLINS

SEE

CERTIFICATE   
96-41581





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 12998  
Items 28a, 28c, 28e 4-30-97 Film G746 W.H. Per Doctor Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

|   |  |   |  |                                   |
|---|--|---|--|-----------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>WILLIE MELVIN CROWDER</b>                |  | 2. Date of Death<br>Month <b>April</b> Day <b>23</b> Year <b>1997</b> |  | 3. Time of Death<br><b>7:00pm</b> |
| 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b> |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>              |  | 4c. County of Death<br><b>N/A</b> |

Funeral  
Director

|   |  |  |                                |                                |  |  |
|---|--|--|--------------------------------|--------------------------------|--|--|
| 5. Social Security Number<br><b>243-36-6540</b> | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs. | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>05/02/1927</b> | 9. Birthplace (State or Foreign Country)<br><b>N. Carolina</b> |
|---|--|--|--------------------------------|--------------------------------|--|--|

Usual Residence of Decedent

|                         |                           |   |  |
|-------------------------|---------------------------|---|--|
| 10a. State<br><b>MD</b> | 10b. County<br><b>N/A</b> | 10c. City, Town or Location<br><b>Baltimore</b> | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|-------------------------|---------------------------|---|--|

|  |                               |  |
|--|-------------------------------|--|
| 10e. Street and Number<br><b>5610 Elderon Avenue</b> | 10f. Zip Code<br><b>21215</b> | 10g. Citizen of What Country?<br><b>U.S.A.</b> |
|--|-------------------------------|--|

|  |   |  |   |
|--|---|--|---|
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |
|--|---|--|---|

|   |  |  |
|---|--|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b><br>College (1-4 or 5+) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Hot Bed Operator</b> | 16b. Kind of Business/Industry<br><b>Bethlehem Steel</b> |
|---|--|--|

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>Willie S. Crowder</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maxine Crowder</b> |
|---|--|

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Hallie P. Crowder</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5610 Elderon Avenue, Balto., MD 21215</b> |
|--|---|

|   |  |      |  |
|---|--|------|--|
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place) <b>4/28</b><br><b>Garrison Forest Vet. Cem.</b> | Date | 20c. Location - City or Town, State<br><b>Owings Mills, MD</b> |
|---|--|------|--|

|  |  |
|--|--|
| 21. Signature of Funeral Service Licentiate<br><i>Leroy O. Dyett</i> | 22. Name and Address of Facility<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME, P.A.<br/>4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b> |
|--|--|

|  |  |
|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute myocardial infarction</b><br>Due to (or as a consequence of):<br><b>b. A.S.C.V.D.</b><br>Due to (or as a consequence of):<br><b>c. Hypertension</b><br>Due to (or as a consequence of):<br><b>d.</b> | Approximate Interval Between Onset and Death<br><b>10 yrs</b><br><b>10 yrs</b> |
|--|--|

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

|  |
|--|
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|--|

|   |  |
|---|--|
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|---|--|

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
|---|--|

|   |  |                                 |   |                                   |
|---|--|---------------------------------|---|-----------------------------------|
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day, Year)<br><b>4/23/97</b> | 28b. Time of Injury<br><b>M</b> | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
|---|--|---------------------------------|---|-----------------------------------|

|   |  |
|---|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Funeral Home</b> | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|--|

|  |   |                                      |   |
|--|---|--------------------------------------|---|
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29b. Signature and title of certifier<br><i>[Signature]</i> | 29c. License number<br><b>D21744</b> | 29d. Date signed (Month, Day, Year)<br><b>4/25/97</b> |
|--|---|--------------------------------------|---|

|  |
|--|
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>KWANG H. LEE, M.D. 1576 Merritt Blvd. Balt.</b> |
|--|

|   |   |
|---|---|
| 31. Date filed (Month, Day, Year)<br><b>APR 30 1997</b> | 32. Registrar's Signature<br><i>[Signature]</i> |
|---|---|

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 12999

## Certificate of Death

Reg. No.

|  |   |   |  |   |   |   |  |  |   |  |
|--|---|---|--|---|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>STELLA J. CARTER</b>                                   |   |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 26, 1997</b> |   |  |  | 3. Time of Death<br><b>5:30 A.M.</b>                        |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>FREDERICK VILLA NURSING HOME</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>CATONSVILLE</b>  |   |  |  | 4c. County of Death<br><b>BALTIMORE</b>                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-74-1168</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br><b>FEB 25, 1907</b> |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |  |
|  | Usual Residence of Decedent   |   |  |   |   |   |  |  |   |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>CATONSVILLE</b>   |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>1404 HABERSON ROAD</b>  |   |   |  | 10f. Zip Code<br><b>21228</b>   |   |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b><br>College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |   |   |  | 16b. Kind of Business/Industry<br><b>HOMEMAKING</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>HARRY ADRIAN SPRINGER</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BERTHA McCARRIAR</b>  |   |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DOROTHY A. HAJEK (DAUGHTER)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1404 HABERSON ROAD - CATONSVILLE, MD 21228</b>  |   |   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CARROLL CREMATION SERVICE</b>  |   | Date<br><b>4/28/97</b>  |  | 20c. Location - City or Town, State<br><b>HAMPSTEAD, MD</b>  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>  |   |   |  |  |   |  |
| 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)<br/><b>a. metastatic adenocarcinoma of the colon</b><br/>Due to (or as a consequence of):</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br/><b>b. Due to (or as a consequence of):</b><br/><b>c. Due to (or as a consequence of):</b><br/><b>d. Due to (or as a consequence of):</b></p> </div> <div style="width: 15%; text-align: right;"> <p>Approximate Interval Between Onset and Death<br/><b>6-8 months</b></p> </div> </div> |   |   |  |   |   |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>dementia</b>  |   |   |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |   |   |  |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |   |   |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
|  |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |   |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>D21928</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>April 28th/1997</b>                               |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. LEONEL BARAHONA - 3459 ST. JOHNS LANE-SUITE 4-ELLCOTT CITY, MD. 21045</b>   |   |   |  |   |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 30 1997</b><br>  |   |   |  |   |   |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 8 per FH Film G746 4-30-97 rja

## Certificate of Death

Reg. No.

97 13000

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ada F. Cole

2. Date of Death

April 22, 1997

3. Time of Death

4:00PM

4a. Facility Name (If not institution, give street and number)

5511 Dolores Ave.

4b. City, Town, or Location of Death

Arbutus

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-09-8953

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01-02  
Jan 15, 1915

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5511 Dolores Ave.

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Alfred E. Cole

18. Mother's Name (First, Middle, Maiden Surname)

Margaret A. Riley

19a. Informant's Name/Relationship (Type, Print)

Michelle Long Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Silerton Road #2D Lansdowne, Md 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery  
Crownsville

Date

April 29, 1997

20c. Location - City or Town, State

Maryland  
Crownsville

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Ambrose Funeral Home, Inc.  
1328 Sulphur Spring Road  
Arbutus, Maryland 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute Myocardial Infarction  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

few hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-40521

29d. Date signed (Month, Day, Year)

April 25, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR MAKESH S. OCHANEY

3300 WILKENS AVENUE SUITE 302  
BALTIMORE, MD 21228

31. Date filed (Month, Day, Year)

APR 30 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

